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In The
Supreme Court of the United States

GREENVILLE WOMEN'S CLINIC;
WILLIAM LYNN, M.D., ON BEHALF OF THEMSELVES
AND THEIR PATIENTS SEEKING ABORTIONS,

Petitioners,

v.

COMMISSIONER, SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL
CONTROL; GOVERNOR OF SOUTH CAROLINA;
CHARLES MOLONY CONDON, IN HIS OFFICIAL
CAPACITY AS ATTORNEY GENERAL OF THE
STATE OF SOUTH CAROLINA,

Respondents.

On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Fourth Circuit

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United States Court of Appeals,
Fourth Circuit.

GREENVILLE WOMEN'S CLINIC; William Lynn, MD, on behalf of themselves and their patients seeking abortions, Plaintiffs-Appellants,
and
Charleston Women's Medical Clinic, Incorporated, Plaintiff,

v.

COMMISSIONER, SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL; Governor of South Carolina; Charles Molony Condon, in his official capacity as Attorney General of the State of South Carolina, Defendants-Appellees.

GREENVILLE WOMEN'S CLINIC; William Lynn, MD, on behalf of themselves and their patients seeking abortions, Plaintiffs-Appellees,
and
Charleston Women's Medical Clinic, Incorporated, Plaintiff,

v.

Commissioner, South Carolina Department of Health and Environmental Control;

Governor of South Carolina; Charles Molony Condon, in his official capacity as Attorney General of the State of South Carolina, Defendants-Appellants.

Nos. 01-2090, 01-2235.

Argued Apr. 5, 2002.
Decided Sept. 19, 2002.

Appeals from the United States District Court for the District of South Carolina, at Greenville. Henry M. Herlong, Jr., District Judge. (CA-96-1898-6-20).

ARGUED: Bonnie Scott Jones, THE CENTER FOR REPRODUCTIVE LAW & POLICY, New York, New York, for Appellants. Boyd Benjamin Nicholson, Jr., HAYNSWORTH, SINKLER, BOYD, P.A., Greenville, South Carolina, for Appellees. **ON BRIEF:** Randall Scott Hiller, Greenville, South Carolina, for Appellants. George Dewey Oxner, Jr., Floyd Matlock Elliott, HAYNSWORTH, SINKLER, BOYD, P.A., Greenville, South Carolina; Charles Molony Condon, James Emory Smith, Jr., OFFICE OF THE ATTORNEY GENERAL, Columbia, South Carolina; Nancy Staats Layman, DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL, Columbia, South Carolina, for Appellees.

Before NIEMEYER and KING, Circuit Judges, and JAMES H. MICHAEL, JR., Senior United States District Judge for the Western District of Virginia, sitting by designation.

Affirmed in part and reversed in part by published opinion. Judge NIEMEYER wrote the opinion, in which

Senior Judge MICHAEL joined. Judge KING wrote a dissenting opinion.

OPINION

NIEMEYER, Circuit Judge.

***1** This appeal continues our review of the facial constitutional challenges made by abortion clinics in South Carolina to Regulation 61-12 of the South Carolina Department of Health and Environmental Control, establishing standards for licensing abortion clinics. In *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000), *cert. denied*, 531 U.S. 1191 (2001) ("*Bryant I*"), we held (1) that Regulation 61-12 did not place an undue burden on a woman's decision whether to seek an abortion in violation of the liberty interest protected by the Due Process Clause and (2) that the regulation did not distinguish unreasonably between clinics that performed a specified number of abortions and those that did not in violation of the Equal Protection Clause.

On remand, the district court addressed the remaining challenges made to Regulation 61-12, rejecting the abortion clinics' contentions that the regulation unconstitutionally delegates licensing authority to nongovernmental third parties without standards; that it violates the Establishment Clause of the First Amendment; and that it is void for vagueness. The district court did, however, conclude that § 102(F) of the regulation, which provides South Carolina inspectors access to records of abortion clinic patients, infringes on a constitutional right to informational privacy insofar as it authorizes the disclosure of patients' names to State inspectors.

On the cross-appeals of the parties, we reject all of the remaining constitutional challenges to Regulation 61-12 and accordingly affirm in part and reverse in part.

I

As authorized in §§ 44-41-10 *et seq.* and 44-7-110 *et seq.* of the Code of Laws of South Carolina, the South Carolina Department of Health and Environmental Control ("DHEC") promulgated Regulation 61-12, entitled "Standards for Licensing Abortion Clinics." Because Regulation 61-12, which comprehensively regulates abortion clinics in South Carolina, was summarized more fully in *Bryant I,* 222 F.3d at 160-62, we only briefly summarize its ten chapters here:

Chapter 1, entitled "Definitions and Requirements for Licensure," includes definitions of relevant terms and sets forth the general requirement that abortion clinics in South Carolina be licensed and subject to inspections. A regulated abortion clinic is defined as "[a]ny facility, other than a hospital as defined in Section 101.J, in which any second trimester or five or more first trimester abortions per month are performed." DHEC Reg. 61-12, § 101(B). Any facility in violation of the regulation may be subjected to civil penalties, including suspension or revocation of its license or a monetary fine. *Id.* § 103.

Chapter 2, entitled "Administration and Management," describes operational policies and procedures, as well as personnel requirements. It also includes a summary of the patients' rights. *Id.* § 209.

Chapter 3, entitled "Patient Care," prescribes minimum procedures required in the treatment of all patients and a limitation of the procedures that may be provided at the facility. The chapter includes admissions criteria, staff responsibilities, and details regarding abortion procedure and follow-up care. *Id.* § 301. Also included within this chapter are certain facility requirements, such as pharmaceutical capabilities and laboratories. *Id.* §§ 303, 304. There is a specification of minimum equipment and supplies, *id.* § 306, and a requirement that clinics implement an ongoing plan for improvement of patient care, *id.* § 308. The chapter further specifies that for purposes of emergency care, staff or con-

sulting physicians shall have admitting privileges at a local hospital that has appropriate obstetrical and gynecological services. *Id.* § 305. Finally, the chapter requires that abortion clinics make arrangements for consultation or referral services "in the specialties of obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, clergy, and social services, as well as any other indicated field, to be available as needed." *Id.* § 307.

*2 Chapter 4, entitled "Medical Records and Reports," sets forth detailed requirements for the generation of patient records, which must be maintained and stored in a "safe location" for at least ten years. *Id.* §§ 401, 402. This chapter also requires abortion clinics to report to the appropriate State agency each abortion performed, each "fetal death" when the fetus has developed beyond a certain stage, and each "accident or incident occurring in the facility which involves patients, staff, or visitors." *Id.* § 403.

Chapter 5, entitled "Functional Safety and Maintenance," deals with safety in clinics' handling of hazardous materials, needles, syringes, and similar materials. *Id.* § 501. It also requires the maintenance of emergency equipment and a plan for disaster preparedness. *Id.* §§ 502, 503.

Chapter 6, entitled "Infection Control and Sanitation," describes procedures for maintaining sterilized supplies and equipment, as well as requirements for having clean linen and towels, clean facilities and grounds, and waste disposal.

Chapter 7, entitled "Fire Protection and Prevention," details specific requirements for fire protection and safety, including mandatory fire drills and alarm testing.

Chapter 8, entitled "Design and Construction," sets forth requirements for approval of the design and construction of abortion clinics and includes requirements for specific types of rooms, security, and equipment.

Chapter 9, entitled "Prerequisites for Initial Licensure," includes the requirements for plan and construction approval,

the existence of documentation demonstrating licensure, and the necessary facility permits.

Finally, Chapter 10, entitled "General," states in its entirety, "Conditions arising that have not been addressed in these regulations shall be managed in accordance with the best practices as interpreted by the Department."

On June 27, 1996, one day before Regulation 61-12 was to become effective, the plaintiffs — two abortion clinics and a doctor operating abortion clinics — commenced this action on behalf of themselves and their patients to obtain a declaratory judgment that Regulation 61-12 was facially unconstitutional on numerous grounds. The district court agreed with the plaintiffs in part, finding that Regulation 61-12 placed an undue burden on a woman's Fourteenth Amendment due process right to choose whether to seek an abortion and that the regulation violated the Equal Protection Clause of the Fourteenth Amendment by treating abortion clinics differently than other healthcare facilities without a rational basis for doing so. *Greenville Women's Clinic v. Bryant,* 66 F. Supp.2d 691 (D.S.C. 1999). Because the district court struck down the regulation on two different grounds, it did not decide the plaintiffs' other constitutional challenges.

On appeal, we reversed, holding that Regulation 61-12 did not impose an undue burden on a woman's right to choose whether to seek an abortion and that South Carolina had a rational basis for treating abortion clinics differently from other medical facilities. *Bryant I,* 222 F.3d at 171-72, 174. We found that Regulation 61-12 serves a valid purpose in safeguarding the health of women and does not aim directly at a woman's right to make the decision to have an abortion. The $23-$75 increased cost per abortion attributable to compliance with Regulation 61-12 was, we held, an incidental effect that, while making abortions modestly more expensive, did not unduly burden a woman's right to make the abortion decision. *Id.* at 169-72. Because the regulation did not strike at the abortion-decision right itself, we also ap-

plied a rational-basis standard to the equal protection analysis and concluded that South Carolina had a rational basis for regulating abortion clinics while not regulating other healthcare facilities. We noted that abortions are "inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life." *Id.* at 174 (quoting *Harris v. McRae,* 448 U.S. 297, 325 (1980) (emphasis omitted)). At bottom, we concluded that "[a] woman in South Carolina who has determined to abort the life of a fetus can do so without significant interference from South Carolina's regulations and be assured thereby of a dignified and safe procedure." *Id.* at 175.

*3 After the Supreme Court denied the plaintiffs' petition for a writ of certiorari, *see* 531 U.S. 1191 (2001), we remanded the case to the district court to address the plaintiffs' other constitutional challenges.

On remand, the district court rejected all but one of the plaintiffs' other constitutional challenges, concluding that Regulation 61-12 did not improperly delegate veto power to third parties; that it did not violate the Establishment Clause of the First Amendment; and that it was not unconstitutionally vague. The Court did, however, find that § 102(F)(2) violated patients' right to privacy insofar as it authorized State inspectors access to patients' records in which the patients were identified. Greenville Women's Clinic and William Lynn, M.D. (hereafter, "the abortion clinics") appealed the district court's rulings upholding the constitutionality of Regulation 61-12, and South Carolina cross-appealed the district court's ruling finding § 102(F)(2) in violation of patients' privacy rights.

II

The abortion clinics contend first that Regulation 61-12 provides for the standardless delegation of licensing authority to third persons, in violation of the Due Process Clause. They assert that the regulation makes licensing "contingent upon the cooperation of hospitals, clergy and other third par-

ties, upon whose decisions the regulation imposes no standard or limitation." To support this argument, they rely on *Yick Wo v. Hopkins,* 118 U.S. 356, 370 (1886), and *Hornsby v. Allen,* 326 F.2d 605, 608 (5th Cir. 1964).

Although Regulation 61-12 does not directly grant any veto power to third persons over the issuance of a license, it does require, as a condition of licensure, that clinic doctors maintain certain admitting rights with local hospitals and referral arrangements with other relevant experts. Specifically, Regulation 61-12 requires (1) that each abortion clinic have an agreement with a physician board-certified in obstetrics and gynecology who has admitting privileges at a local hospital to be available during "operating-hours," DHEC Reg. 61-12, § 205(c)(2); (2) that a physician at the clinic have admitting privileges at a local hospital with "obstetrical/gynecological services," *id.* § 305(A); *see also id.* § 309(B); and (3) that each abortion clinic make arrangements for referral services "in the specialties of obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, clergy, and social services, as well as any other indicated field, to be available as needed," *id.* § 307.

South Carolina argues that these admitting privileges and referral arrangements are necessary for the health and safety of patients. Moreover, it points out that these requirements are consistent with existing standards of the American College of Obstetricians and Gynecologists, as stated in its "Standards for Obstetric-Gynecologic Services" (7th ed. 1995), and of the National Abortion Federation, as stated in its "Standards for Abortion Care" (1988). It also denies that the regulation gives any of the third party specialists a veto power over licensure of abortion clinics and notes that, in practice, the abortion clinics' fears about being denied a license or losing their license because of any inability to establish such arrangements are not supported by the record. Indeed, both Greenville Women's Clinic and Dr. Lynn, the

appellants in this case, are already licensed in South Carolina to perform abortions, and both have admitting privileges or arrangements with physicians who have admitting privileges at local hospitals with obstetrical and gynecological services. This evidence, South Carolina argues, is "fatal" to the abortion clinics' position.

*4 We begin by emphasizing, as we did in *Bryant I,* that the challenge to Regulation 61-12 is a facial one and therefore "the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid." *United States v. Salerno,* 481 U.S. 739, 745 (1987). To show the necessary respect to legislative departments, particularly in light of Article III's limitation of judicial power to cases and controversies, we require evidence — as opposed to speculation — sufficient to rebut the regulation's presumptive constitutionality. Yet, in this record, we find only speculation.

There is nothing in the record or, indeed, in the general experience in South Carolina that suggests that the requirements to have admitting arrangements with local hospitals and referral arrangements with local experts in various related fields present a substantial impediment to obtaining or retaining a license. To the contrary, the appellants in this case have obtained licenses and have made such arrangements. The abortion clinics' asserted fears are further undermined by South Carolina's requirement that public hospitals not act unreasonably, arbitrarily, capriciously, or discriminatorily in granting or denying admitting privileges. *See, e.g., In re Zaman,* 329 S.E.2d 436, 437 (S.C. 1985); *cf. Huellmantel v. Greenville Hosp. Sys.,* 402 S.E.2d 489, 491 (S.C. Ct. App. 1991) (stating that a physician's interest in being reappointed to a public hospital staff is protected by procedural and substantive due process requirements of the Fourteenth Amendment). The required referral arrangements present even lower practical barriers. Indeed, they are re-

quired to be made only "as needed." *See* DHEC Reg. 61-12, § 307.

These requirements of having admitting privileges at local hospitals and referral arrangements with local experts are so obviously beneficial to patients, *see, e.g., Women's Health Ctr. of West County, Inc. v. Webster,* 871 F.2d 1377, 1382 (8th Cir. 1989), and the possibility that the requirements will amount to a third-party veto power is so remote that, on a facial challenge, we cannot conclude that the statute denies the abortion clinics due process. *See Whalen v. Roe,* 429 U.S. 589, 601-02 (1977) (noting that, on a facial challenge of a statute, a "remote possibility" is "not a sufficient reason for invalidating" a statute); *see also Webster,* 871 F.2d at 1382 (rejecting due process challenge to a statute requiring physicians performing abortions to have surgical privileges at a hospital). This conclusion is further reinforced by the right given by Regulation 61-12, § 102(L), for clinics to seek a waiver or exception.

Accordingly, we reject the abortion clinics' due process challenge to Regulation 61-12 based on the regulation's requirement that abortion clinics have admitting privileges to local hospitals and referral arrangements with relevant experts.

III

The abortion clinics also contend that § 307 of Regulation 61-12 is a State-sponsored "law respecting an establishment of religion," as prohibited by the First and Fourteenth Amendments. Section 307 provides in relevant part:

> Arrangements shall be made for consultation or referral services in the specialties of ... clergy ..., to be available as needed.

***5** The abortion clinics contend that this section requires that the clinics "establish formal, ongoing relationships with clergy persons who will be available to provide counseling services to their patients upon referral." And they

argue that "[u]nder the provision, [the abortion clinics] must assess their patients' need for religious counseling and make referrals to such counseling as part of their practice of medicine. To enforce the regulation, DHEC must assess the adequacy of [the abortion clinics'] criteria and mechanisms for making such referrals." Relying on this reading of § 307, the abortion clinics maintain that the regulation violates the Establishment Clause of the First Amendment because (1) it coerces participation in religion; (2) it improperly entangles the State in religion; and (3) it creates "a symbolic union between church and state."

We conclude, however, that the abortion clinics' argument is grounded on a substantial misreading of § 307, imputing obligations and relationships that are not prescribed by the regulation. Section 307 does not require abortion clinics to become involved in religion, or to counsel their patients in religion, or to make any religious judgments. Rather, they are required only to have "arrangements" for referring patients to clergy "as needed." These arrangements might amount to no more than a list of clergy and other specialists or a readily accessible telephone book to consult as required by the needs of a particular patient. Since the need for a referral cannot be known until the patient requests a referral, the "arrangement" cannot be made until then. And even then it need not involve more than a communication to a clergy member expressing the patient's request and perhaps setting up a consultation time.

The requirements of § 307 simply cannot be construed to "force physicians to participate in religion," or to "assess patients' needs for religious counseling," or to "force physicians to support religion" — as the abortion clinics in this case argue. Moreover, the language of the regulation does not support the abortion clinics' contention that the DHEC may evaluate whether abortion clinics have established an adequate system, adequate number, or adequate variety of clergy to whom referrals might be made. Finally, § 307 does

not grant the religious community any veto power over the clinic's licensing application "thus creating a symbolic union between church and state." Because the section calls for arrangements "as needed," a clinic need not assist the patient by making a referral to clergy unless the patient so requests.

*6 Rather than establishing religion, this section would appear at most to require a clinic to accommodate the requests of patients to exercise religion, a right also protected by the First Amendment. *See* U.S. CONST. amend. I (forbidding any law that "prohibits the free exercise" of religion). Particularly because of the gravity of a woman's right to make the abortion decision, the regulation recognizes the patient's potential desire to consult clergy in making that decision. As the Supreme Court observed in *Planned Parenthood of S.E. Penn. v. Casey,* "the abortion decision ... is more than a philosophic exercise. Abortion is a unique act [that is] fraught with consequences." 505 U.S. 833, 852 (1992). And similarly, we observed in *Bryant I:*

> As humankind is the most gifted of living creatures and the mystery of human procreation remains one of life's most awesome events, so it follows that the deliberate interference with the process of human birth provokes unanswerable questions, unpredictable emotions, and unintended social and, often, personal consequences beyond simply the medical ones.

222 F.3d at 175.

Accordingly, we conclude that the requirement imposed by § 307 on abortion clinics to make arrangements for referral services to clergy, as needed, does not, on its face, establish religion in violation of the First Amendment. *Cf. Brown v. Gilmore,* 258 F.3d 265 (4th Cir. 2001) (holding that a State statute requiring a moment of silence to enable students to meditate, *pray,* or engage in any other silent activity does not

establish religion in violation of the First Amendment), *cert. denied,* 122 S. Ct. 465 (2001). In so concluding, we note that this facial challenge cannot encompass every way in which the DHEC might require a clinic to comply with § 307. Specific instances of enforcement may, of course, still be challenged on a case-by-case basis as they occur.

IV

Finally, the abortion clinics contend that Regulation 61-12 is void for vagueness, in violation of the Due Process Clause. They contend that the regulation contains a number of requirements that employ "open-ended" terms lacking any fixed meaning, such as "best practice" or "case-by-case" basis. They maintain that the regulation uses ambiguous adjectives, such as "intensive job-related training," which qualifies a non-physician for work at a clinic. They assert that the regulation contains misnomers, giving as an example that the facilities must be kept "neat, clean and free from odors" and noting that because every medical office has odors, the regulation cannot mean what it says. Finally, they point to inherently ambiguous requirements such as the requirement that "all staff *and/or* consulting physicians shall have admitting privileges at one or more local hospitals." The abortion clinics have identified the following list of provisions that they challenge, and they suggest that this list is not exhaustive:

> *7 1. Section 102(J), which prohibits using an abortion facility name that is similar to the name of another such facility, but does not define how "similarity" will be determined.
>
> 2. Section 102(L), which allows DHEC to make exceptions to Regulation 61-12 "where it is determined that the health and welfare of the community require the services of the facility."

3. Section 103(F), which gives DHEC discretion with respect to a particular violation to impose any penalty within the range of possible penalties.

4. Section 201(B), which requires abortion providers to create, and DHEC to assess, policies and procedures on such matters as "patient rights" and "functional safety."

5. Section 204, which requires that staff be "adequately trained and capable of providing appropriate service and supervision to the patients."

6. Section 204(A), which requires that a provider "verify" an employee's "health and personal background."

7. Section 204(D), which prohibits employees and volunteers with "any ... contagious disease or illness [from working] in any capacity in which there is a likelihood of such person transmitting disease to other individuals."

8. Section 205(C)(1), which requires physicians performing abortions to be "properly qualified by training and experience to perform pregnancy termination procedures."

9. Section 301, which requires the creation of various policies and procedures "designed to ensure professional and safe care for patients."

10. Section 305(A), which requires that "all staff and/or consulting physicians shall have

admitting privileges at one or more local hospitals."

11. Section 306, which requires that "appropriate equipment and supplies" be maintained, with no specific requirements.

12. Section 307, which requires among the required consultation services, "any other indicated field, to be available as needed."

13. Sections 308(A) and (C), which require abortion facilities to establish a quality improvement plan that involves "criteria-based" evaluation of patient care.

14. Section 501(A), which requires abortion facilities to promulgate a range of policies and procedures "to enhance safety."

15. Section 602(A), which requires adequate space for sterile supplies and equipment.

16. Section 604, which requires that the facilities "be kept neat, clean and free from odors."

17. Section 606, which requires that "all outside areas ... shall be kept free of ... grass ... that may serve ... as a haven for insects."

18. Section 807, which requires that an "adequate number of examination/procedure rooms" and an "adequate number of recovery rooms" be provided.

19. Chapter 10, which states in its entirety, that "[c]onditions arising that have not been

> addressed in these regulations shall be managed in accordance with the best practices as interpreted by the Department."

In sum, the abortion clinics complain that Regulation 61-12 does not provide sufficient specifics to explain what conduct is actually mandated or prohibited.

***8** The district court reviewed the abortion clinics' "litany of phrases which [were] allegedly unconstitutionally vague," and after considering the phrases in their context and taking Regulation 61-12 as a whole, the court concluded that "people of ordinary intelligence would be able to understand what the regulation requires." The court also stated that the regulation "does not encourage arbitrary and discriminatory enforcement. In fact, it appears that the majority of Regulation 61-12 is identical to the American College of Obstetricians and Gynecologists ("ACOG") standards for obstetricians and gynecologists."

"A statute can be impermissibly vague for either of two independent reasons. First, if it fails to provide people of ordinary intelligence a reasonable opportunity to understand what conduct it prohibits. Second, if it authorizes or even encourages arbitrary and discriminatory enforcement." *Hill v. Colorado,* 530 U.S. 703, 732 (2000). But because we are "condemned to the use of words, we can never expect mathematical certainty from our language." *Grayned v. City of Rockford,* 408 U.S. 104, 110 (1972). As such, a regulation is not void for vagueness unless it is so unclear with regard to what conduct is prohibited that it "may trap the innocent by not providing fair warning," or it is so standardless that it enables "arbitrary and discriminatory enforcement." *Id.* at 108. Furthermore, the degree of clarity required depends on the type of regulation:

> Economic regulation is subject to a less strict vagueness test because its subject matter is often more narrow, and because businesses ...

> can be expected to consult relevant legislation in advance of action.... The Court has also expressed greater tolerance of enactments with civil rather than criminal penalties because the consequences of imprecision are qualitatively less severe.

Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc., 455 U.S. 489, 498-99 (1982) (footnotes omitted).

Although portions of Regulation 61-12 fall short of mathematical precision, we are satisfied that a reasonable person, reading the regulation in its entirety and in the context of South Carolina statutes, would be able to interpret the regulation and determine what is required and what conduct is prohibited. For example, § 205(C)(1), the violation of which would allow the most serious penalty of the sections identified as vague by the abortion clinics, provides that abortion-clinic physicians be "properly qualified by training and experience to perform pregnancy termination procedures." The abortion clinics argue that they do not understand how physicians need to be qualified to satisfy this provision. Yet, physicians routinely hold themselves out as qualified to practice in given areas based on their training and experience, and such a standard is routinely applied in the medical field to define whether a physician breached the ordinary standard of care or whether a physician is competent to perform a specialized surgery. *See, e.g., Hoeffner v. The Citadel,* 429 S.E.2d 190, 192 (S.C. 1993) (requiring expert testimony to determine defendant doctor's standard of care and breach thereof). In short, physicians have no difficulty in stating that they are qualified by training and experience to practice in a given area or to perform specified procedures. We believe that the other challenged provisions can similarly be followed by reasonably prudent abortion providers who are mindful of their patients' health and safety.

***9** The most unclear provision in Regulation 61-12 may be Chapter 10, which provides that "[c]onditions arising

that have not been addressed in these regulations shall be managed in accordance with the best practices as interpreted by the Department." But this provision essentially appears to give the DHEC no power beyond its ability to promulgate further regulations as they become necessary. Moreover, any violation of Chapter 10 could only amount to a "Class III" violation, which would call for nothing more than a warning sanction. Accordingly, we can see no reason to conclude that the imprecision of this particular provision violates the abortion clinics' due process rights.

In addition to concluding that persons of reasonable intelligence would be able to understand what is required of them by Regulation 61-12, we note that the penalties are civil rather than criminal. Regulation 61-12 divides its penalties into three classes, and a Class I offense, the most serious, is subject, on the first offense, to a maximum fine of $1,000. DHEC Reg. 61-12, § 103(F). A Class II offense is subject, on the first offense, to a maximum fine of $500, *id.*, and a Class III offense, on the first offense can lead at most, to a warning, *id.* Even when a fine is called for, there are suggested factors for determining the amount, including the facility's efforts to correct the identified problem, the facility's overall conditions, and the facility's history of compliance. *Id.* § 103(E). This consideration of the violator's good faith effort to comply makes arbitrary enforcement even less likely. Moreover, as observed in *Village of Hoffman Estates,* we can expect abortion clinics to consult relevant legislation in advance of action or to seek clarification from appropriate administrative sources when necessary. *See* 455 U.S. at 498.

In the context of a facial challenge to a regulation, it is inappropriate to speculate regarding a worst-case scenario. *See Hill,* 530 U.S. at 733 (noting that "speculation about possible vagueness and hypothetical situations not before the Court will not support a facial attack on a statute when it is surely valid 'in the vast majority of its intended applications'" (quoting *United States v. Raines,* 362 U.S. 17, 23

(1960))). Accordingly, we affirm the district court's conclusion that Regulation 61-12 is not unconstitutionally vague.

V

South Carolina, in its cross-appeal, challenges the district court's ruling that § 102(F)(2) of Regulation 61-12 is unconstitutional. That section provides: "Department inspectors shall have access to all properties and areas, objects, records and reports, and shall have the authority to make photocopies of those documents required in the course of inspections or investigations." The district court stated that because South Carolina identified "no compelling interest in the disclosure of identifying information" — i.e., information that reveals to the State the names of patients procuring abortions — § 102(F)(2) violates the patient's constitutional right to privacy "insofar as it requires access to identifying information." In a footnote, the court allowed that "[t]his constitutional problem can be cured by the plaintiffs redacting the documents to remove such information." South Carolina contends that, notwithstanding the district court's conclusion, it needs the information to monitor abortions and to assure compliance with the health-care standards in Regulation 61-12 aimed at preserving maternal health. It notes that even the National Abortion Federation, in its "Standards for Abortion Care," states that the "maintenance of complete and accurate records is essential for quality patient care and meaningful review of services." The Federation's "Standards of Abortion Care" explains that the "reporting of abortion procedures and complications to appropriate private and legally sanctioned public agencies generally improve[s] family planning services and public health information." In addition, South Carolina argues that its statutes and regulations provide adequately for the privacy of patients' records.

***10** The abortion clinics contend, on the other hand, that disclosure of patients' names and records violates the patients' privacy rights as defined in *Whalen v. Roe,* 429 U.S. 589, 597 (1977) (recognizing a right to privacy "in avoiding

disclosure of personal matters"), and *Walls v. City of Petersburg*, 895 F.2d 188, 192 (4th Cir. 1990) (requiring the State to offer a "compelling" interest before disclosing protected information). They argue that the confidentiality of patient information is "vital to women seeking abortions because they may face harassment from their partners, co-workers, and others for having decided to undergo an abortion." And they maintain that disclosing the information also "may force patients to delay their abortions until they can go to a state where their confidentiality will be maintained; to go to an unlicenced provider; or to attempt to self-abort [sic]. Each of these alternatives poses serious risks to patient health."

South Carolina's abortion statute requires that each abortion be reported to the DHEC within seven days after the abortion is performed. *See* S.C. Code Ann. § 44-41-60. The same statute authorizes the DHEC to promulgate regulations for the maintenance of medical records and reports. *See id.* §§ 44-41-70, 44-41-75.

To carry out its mandate, the DHEC promulgated Regulation 61-12, comprehensively providing for the generation and maintenance of records and reporting as necessary to carry out the licensing and regulation of abortion clinics. Regulation 61-12 requires that written consent be obtained from each patient obtaining an abortion and that a copy of the consent be maintained in the patient's record. *See* DHEC Reg. 61-12, § 201(b)(10). The regulation prescribes a list of items that must be included in patients' medical records relating to any abortion procedure performed and requires that the records be maintained in a safe location for a minimum of ten years. *See id.* §§ 401, 402. It also requires that each laboratory test be documented in a report and maintained as part of the patient's record. *See id.* § 304(E). With respect to each employee at an abortion clinic, Regulation 61-12 requires that the clinic maintain a personnel file, documenting the employee's job description, work assignments, in-service education, licensure, if applicable,

and tuberculosis skin-testing. *See id.* § 204(H). In-service training programs, providing employees training in specified areas at least once annually, must also be documented, reflecting the program's contents and attendance. *See id.* § 204(F). The regulation also requires that clinics maintain records of all controlled substances. *See id.* § 303(F). It mandates that the clinics conduct sterilization procedures and maintain records of those procedures, as well as safety-testing equipment and alarms. *See id.* §§ 602(C), 702. And the regulation requires that the clinic maintain on its premises the documentation evidencing its licensure in a manner sufficient to inform patients. *See, e.g., id.* §§ 203, 208, 209.

***11** In addition to its requirements for generating and maintaining records, Regulation 61-12 imposes reporting requirements. Abortion clinics must report each abortion and each accident or incident to the Vital Records and Public Health Statistics section of the DHEC. *See id.* § 403. In addition, the abortion clinics are subject to regular inspections, and DHEC inspectors are given access to all "records and reports" and authority to make photocopies of those documents "required in the course of inspections or investigations." *See id.* § 102(F)(2).

The abortion clinics do not seriously challenge the requirement of generating and maintaining records. Indeed, they would have to acknowledge that each type of record relates directly to the health or safety requirements imposed by Regulation 61-12. And the Supreme Court has found that requiring documentation of this type is in the public interest and does not violate any constitutional right to privacy. *See Whalen v. Roe,* 429 U.S. 589 (1977); *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52 (1976).

In *Whalen,* the Supreme Court upheld, against constitutional attack, the maintenance of a centralized State computer file that contained the names and addresses of all persons who had obtained certain prescription drugs, for which there was both a lawful and an unlawful market. Recognizing that

patients have a protected interest "in avoiding disclosure of personal matters" as well as an interest in "independence in making certain kinds of important decisions," 429 U.S. at 599-600, the Supreme Court nonetheless held that "the New York program does not, on its face, pose a sufficiently grievous threat to either interest to establish a constitutional violation." *Id.* at 600. The Court noted that the invasions of privacy necessary for the public health were not "meaningfully distinguishable from a host of other unpleasant invasions of privacy that are associated with many facets of health care," explaining:

> Unquestionably, some individuals' concern for their own privacy may lead them to avoid or to postpone needed medical attention. Nevertheless, disclosures of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies are often an essential part of modern medical practice even when the disclosure may reflect unfavorably on the character of the patient.

Id. at 602. In response to the appellants' suggestions that the information could become public through deliberate or negligent conduct in numerous ways, the Court stated that "the remote possibility that judicial supervision of the evidentiary use of particular items of stored information will provide inadequate protection against unwarranted disclosures is surely not a sufficient reason for invalidating the entire patient-identification program." *Id.* at 601-02.

Similarly, in *Danforth,* the patients attacked a record-keeping provision of Missouri's abortion statute contending, among other things, that it invaded the patient's "right to privacy in the physician-patient relationship." 428 U.S. at 57. Under the Missouri statute, abortion providers were required to fill out state forms that were to be maintained confiden-

tially and would be used only for statistical purposes. Nevertheless, the information was reportable to local, state and national public health officers. In upholding these requirements, the Court said: "Recordkeeping and reporting requirements that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible." *Id.* at 80. The Court explained that the requirements of confidentiality and the limited duration of document-maintenance (seven years) "assist[ed] and persuad[ed]" the Court to conclude that the recordkeeping requirement had no "legally significant impact or consequence on the abortion decision or on the physician-patient relationship." *Id.* at 81.

***12** Similarly, we noted in our previous opinion in this case that the recordkeeping and copying requirements were justified to ensure compliance with health care standards. *Bryant I,* 222 F.3d at 171. We added that this was particularly so in view of the regulation's requirement that all records be treated as confidential. While our conclusion in *Bryant I* was limited to holding that the recordkeeping requirement did not unduly burden the abortion decision, the observation is still relevant to this discussion on privacy insofar as it supports a conclusion that recordkeeping requirements are meaningful to the overall health and safety purposes of Regulation 61-12.

Accordingly, we conclude that South Carolina's recordkeeping requirement does not *per se* violate the Constitution. This does not, however, answer the entire question of whether the reporting requirements and the potential for publication through court proceedings renders the requirements unconstitutional, as the abortion clinics argue. South Carolina must still demonstrate that the records it requires that contain personal information will be maintained in confidence to the extent possible as it uses the records to ensure the health and safety of its citizens. *See Whalen,* 429 U.S. at 602 (noting that disclosure to public health agencies are "an

essential part of modern medical practice"); *Walls,* 895 F.2d at 192 (recognizing limits on an individual's right to privacy and requiring the government to move a compelling interest only if there will be disclosure of protected information). We conclude that South Carolina's statutes and Regulation 61-12 assure the patient's confidentiality, such that protected information will not be disclosed.

First, with respect to every facility licensed by the DHEC, the confidentiality of patient files is demanded. Section 44-7-310 of the South Carolina Code provides that the information received by the DHEC "which does not appear on the face of the license may not be disclosed publicly in a manner as to identify individuals or facilities." S.C. Code Ann. § 44-7-310. The only exception provided is for a proceeding involving licensure or an order of court. *Id.* Similarly, § 44-7-315, which authorizes the disclosure of information relating to licensed facilities, provides that "the Department may not disclose the identity of individuals present in a facility licensed by the department pursuant to this article or subject to inspection by the department." S.C. Code Ann. § 44-7-315.

The abortion statute itself, which requires that each abortion be reported to the DHEC, also provides that "the names of the patient and physician may not be reported on the form or otherwise disclosed to the state registrar." S.C. Code Ann. § 44-41-60. Finally, even in a court proceeding involving abortion licensure, the abortion statute requires that the court make an explicit ruling whether "the anonymity of any woman upon whom an abortion is performed or attempted shall be preserved from public disclosure if she does not give her consent to such a disclosure." S.C. Code Ann. § 44-41-360. In making that ruling, the court is explicitly required to apply the appropriate constitutional standard. *See id.*

***13** Consistent with these statutory mandates to preserve the privacy of patients, Regulation 61-12 explicitly requires confidentiality of patients' records. Section 402 pro-

vides that "[a]ll records shall be treated as confidential." Moreover, employees working in abortion clinics must be trained on the "confidentiality of patient information and records, and protecting patient rights." *See* DHEC Reg. 61-12, § 204(F)(3). Section 209 requires that each licensed facility have "written policies and procedures to assure the individual patient the right to dignity, *privacy,* safety, and to register complaints with the department." *Id.* § 209(A) (emphasis added).

While § 102(F) authorizes a State inspector to review records for compliance with the abortion statute and with Regulation 61-12, that authorization to inspect records does not authorize the inspector to breach the statutory and regulatory mandates to protect the patient's privacy. The Supreme Court has recognized that "[r]equiring such disclosures to representatives of the State having responsibility for the health of the community, does not automatically amount to an impermissible invasion of privacy." *Whalen,* 429 U.S. at 602. As the Court observed in *Danforth,* "recordkeeping of this kind, if not abused or overdone, can be useful to the State's interest in protecting the health of its female citizens, and may be a resource that is relevant to decisions involving medical experience and judgment." 428 U.S. at 81.

For these reasons, we conclude that the recordkeeping and information reporting mechanisms adopted by South Carolina in its statutes and in Regulation 61-12 do not require unnecessary disclosure of protected information, in violation of the privacy right identified in *Whalen,* 429 U.S. at 599-600. Even though the abortion clinics can conceive of circumstances where patients' privacy rights could be violated, either deliberately or through negligence, we cannot assume that the confidentiality measures adopted by South Carolina to prevent such violations will be administered improperly. *Whalen,* 429 U.S. at 601-02.

Accordingly, we reverse the district court's conclusion that Regulation 61-12 violates patients' privacy rights, as

identified in *Whalen,* insofar as it permits the disclosure of patient identification to the State officials administering the program. *See Whalen,* 429 U.S. at 602-03 (finding constitutional a State maintained computer file containing the *names* and addresses of patients for whom drugs had been prescribed).

VI

In sum, on the abortion clinics' constitutional challenges to Regulation 61-12 based on (1) a standardless delegation of licensing authority, (2) an alleged violation of the Establishment Clause, and (3) a claim of vagueness, we reject the abortion clinics' arguments and affirm the district court. On South Carolina's cross-appeal challenging the district court's ruling that § 102(F) of Regulation 61-12 is unconstitutional, we reverse.

***14** *AFFIRMED IN PART REVERSED IN PART.*

KING, Circuit Judge, dissenting:

We today address significant questions arising from one of the most divisive and contentious issues in our nation's history. Since *Roe v. Wade* was decided by the Supreme Court in 1973, the struggle over the existence and scope of a woman's constitutional right to choose has been a constant part of our political landscape. In recent years, state legislatures have taken an increasingly active role in regulating access to abortion; in many places, burdensome regulations have made abortions effectively unavailable, if not technically illegal. It is this type of regulation — micromanaging everything from elevator safety to countertop varnish to the location of janitors' closets — that is challenged in this case. 24 S.C. Code Ann. Regs. 61-12 (Cum. Supp. 2001) (the "Regulation").[1]

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[1] Although South Carolina claims that the Regulation treats abortion clinics similarly to other entities regulated by the State, several facts belie this assertion. First, as Judge Hamilton aptly pointed out the first time this case was appealed, "South Carolina does not require licensing of

The State of South Carolina is entitled to make a value judgment, as a matter of its public policy, to favor childbirth over abortion. *Rust v. Sullivan,* 500 U.S. 173, 192-93 (1991); *Maher v. Roe,* 432 U.S. 464, 474 (1977). In accordance with this prerogative, South Carolina has made its preference clear. For example, while a citizen of the Palmetto State may obtain a "Choose Life" automobile license plate from the authorities, he may not obtain a "Choose Choice" license plate.[2] S.C. Code Ann. § 56-3-8910 (West 2002).[3] Insofar as the legislature in South Carolina wishes to limit the choices of its female citizens, it has been largely successful. Eighty percent of the State's counties lack an abortion provider, and between 1992 and 1996, the number of such providers in the State fell from eighteen to fourteen. Stanley K. Henshaw, "Abortion Incidence and Services in the United States, 1995-1996," *Fam. Plan. Persp.,* Vol. 30, No. 6, November/December 1998.

South Carolina is not, however, entitled to adopt and pursue an anti-abortion agenda at the expense of constitutional

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physicians' offices outside of the abortion context." *Greenville Women's Clinic v. Bryant,* 222 F.3d 157, 178 (4th Cir. 2000) (Hamilton, J., dissenting). Second, the South Carolina Department of Health and Environmental Control ("DHEC"), in writing the Regulation, specifically tailored it to abortion clinics. *Id.* at 184-85. Finally, the Regulation contains some provisions, such as the clergy referral requirement discussed below, *see infra* Part II, that are found nowhere else in the South Carolina Code.

[2] I express no view on whether this policy is impacted by our recent decision in *Sons of Confederate Veterans, Inc. v. Commissioner of the Virginia Department of Motor Vehicles,* 288 F.3d 610 (4th Cir. 2002).

[3] Other South Carolina statutes demonstrate a similar hostility to a woman's constitutional right to seek an abortion. *See, e.g.,* S.C. Code Ann. § 1-1-1035 (West 2002) (prohibiting Medicaid funds from being used to fund abortions); S.C. Code Ann. § 44-41-340(A)(2) (West 2002) (requiring that women seeking abortions be provided with a brochure that includes "materials designed to inform the woman of the probable anatomical and physiological characteristics of the embryo or fetus at two-week gestational increments"); S.C. Code Ann. § 44-41-40 (West 2002) (entitling private hospitals to refuse to perform abortions).

rights. Having carefully examined the constitutional challenges made by Greenville Women's Clinic and other abortion providers (collectively, the "Plaintiffs") to aspects of the Regulation, I am inexorably led to conclude that certain of its provisions violate the Constitution. I part company with my friends in the majority in four respects:

> First, the majority improperly reverses the district court on the informational privacy issue;
>
> Second, the majority ignores the conflict between the clergy referral requirement and the Establishment Clause;
>
> Third, the majority upholds unconstitutionally vague and ambiguous provisions of the Regulation; and
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> Fourth, the majority endorses a standardless delegation of state power that contravenes the Due Process Clause.

I will discuss each of these points in turn.[4]

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[4] The majority also improperly focuses on the fact that the Plaintiffs have challenged the Regulation on its face. In *United States v. Salerno,* 481 U.S. 739 (1987), the Supreme Court articulated a "no set of circumstances" test that would, if applicable, make a facial challenge virtually impossible to win. However, the *Salerno* doctrine is an embattled one at best, and its continuing viability is the subject of intense debate. In any event, the Court has indicated that the *Salerno* standard does not apply to three of the four legal claims asserted here. *See Santa Fe Indep. Sch. Dist. v. Doe,* 530 U.S. 290, 313-14 (2000) (analyzing a facial challenge in an Establishment Clause case without applying *Salerno*); *Stenberg v. Carhart,* 530 U.S. 914, 921 (2000) (same for privacy); *Chicago v. Morales,* 527 U.S. 41, 55 (1999) (plurality) (same for vagueness). So long as plaintiffs possess standing to raise a claim, facial challenges are generally evaluated under the same standard as any other constitutional challenge, and the majority simply confuses the issues in suggesting otherwise.

I.

On the first of the Plaintiffs' four challenges to the Regulation, I would affirm the district court and hold § 102(F)(2) (the "Disclosure Provision") to be unconstitutional.[5] The Disclosure Provision concerns the State's access to private medical records,[6] and the district court properly found that South Carolina had failed to demonstrate a sufficient interest in obtaining information identifying the female patients of abortion clinics.[7] The majority incorrectly reverses the district court on this issue.

***15** The Supreme Court has identified two types of privacy rights, both rooted in the Fourteenth Amendment. The first is the right of citizens to make certain personal choices, such as those discussed by the Court in *Roe v. Wade,* 410 U.S. 113 (1973), and its progeny. The second protects "informational privacy," and it consists of a citizen's right to control the release of personal information. *Whalen v. Roe,* 429 U.S. 589, 599-600 (1977). The public disclosure of private medical records, and the personal and confidential in-

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[5] The Disclosure Provision provides, in pertinent part, that:

> Department inspectors shall have access to all ... records and reports, and shall have the authority to make photocopies of those documents required in the course of inspections or investigations.

24 S.C. Code Ann. Regs. 61-12, § 102(F)(2) (Cum. Supp. 2001).

[6] Pursuant to § 401(A)(1) of the Regulation, abortion clinics in South Carolina are required to maintain records with various identifying information, including:

> name, address, telephone number, social security number, date of birth, father's and mother's names when patient is a minor, husband's name, and name, address and telephone number of person to be notified in the event of an emergency.

24 S.C. Code Ann. Regs. 61-12, § 401(A)(1) (Cum. Supp. 2001).

[7] By definition, the Regulation only applies to clinics "in which any second trimester or five or more first trimester abortions per month are performed." 24 S.C. Code Ann. Regs. 61-12, § 101(B) (Cum. Supp. 2001). However, for ease of reference, I use the terms "clinics" or "providers," without any further elaboration, to refer to those facilities subject to the Regulation.

formation contained therein, implicates this informational privacy right.

Of course, the right to informational privacy is not absolute, and a state does not necessarily violate that right by requiring disclosure of private medical records. *Id.* at 602. To determine whether the Disclosure Provision infringes the right to informational privacy, we consider three factors. First, the information must fall within the zone of the constitutional right to privacy. *Walls v. City of Petersburg,* 895 F.2d 188, 192 (4th Cir. 1990). Second, if the information is within this zone, then "the defendant has the burden to prove that a compelling governmental interest in disclosure outweighs the individual's privacy interest." *Id.* Finally, any safeguards provided by the State against improper disclosure will serve to dilute the individual's privacy interest. Overall, the State's need for private information must be balanced against the interest of the person whose privacy is at stake. *Id.* at 192-94. As the district court properly determined, South Carolina has failed to demonstrate a sufficient need for access to patients' private identifying information, rendering its Disclosure Provision invalid. *See Greenville Women's Clinic v. Bryant,* Memorandum of Decision, CA No. 6:96-1898-20 (D.S.C. Aug. 31, 2001) (the "Memorandum of Decision").

A.

The constitutional right to privacy in pregnancy-related medical information is firmly established. Indeed, the Supreme Court has emphasized that the decision of a woman to exercise her constitutional right to choose "is an intensely private one that must be protected in a way that assures anonymity." *Thornburgh v. Am. Coll. of Obstetricians and Gynecologists,* 476 U.S. 747, 766 (1986), *overruled in part on other grounds, Planned Parenthood v. Casey,* 505 U.S. 833 (1992); *see Hodgson v. Minnesota,* 497 U.S. 417, 463 (1990) ("Few decisions are more personal and intimate, more properly private, or more basic to individual dignity and auton-

omy, than a woman's decision ... whether to end her pregnancy.") (quoting *Thornburgh,* 476 U.S. at 772); *see also Skinner v. Ry. Labor Executives' Ass'n,* 489 U.S. 602, 617 (1989) (subjecting drug testing program to scrutiny under the Fourth Amendment because it threatened to reveal private information such as pregnancy). Given the Court's recognition of the private nature of reproductive decisions, the women seeking services at abortion clinics in South Carolina unquestionably possess a constitutionally protected privacy interest in the information sought by the State under the Disclosure Provision.

B.

***16** In assessing the validity of the Disclosure Provision, we must also consider whether South Carolina has established "a compelling governmental interest in disclosure [that] outweighs the individual's privacy interest." *Walls,* 895 F.2d at 192; *see also Carey v. Population Servs. Int'l,* 431 U.S. 678, 686 (1977). In this regard, the pivotal question is whether the State can sufficiently justify its request for disclosure of constitutionally protected information.

The Supreme Court has recognized that a state has an interest in protecting maternal health, and that it may properly collect otherwise private medical information related to this purpose. *See Planned Parenthood of Cent. Mo. v. Danforth,* 428 U.S. 52, 80 (1976). However, as *Walls* informs us: the "regulation 'may be justified only by compelling state interests, and must be narrowly drawn to express only those interests.'" *Walls,* 898 F.2d at 192 (quoting *Carey,* 431 U.S. at 686).

South Carolina has failed to demonstrate that it has a compelling need to copy any patient identifying information. The only justification offered by the State is that such information is needed in order to investigate complaints against abortion clinics. However, the State has failed to demonstrate a need to contact patients in such situations. In fact, complaints involving compliance with issues such as struc-

tural building requirements and staff qualifications could be fully investigated by the State without contacting the female patients. And on issues involving patient care, the affected patients would most likely consent to the disclosure of their identity.

In limited situations, the State might have a valid need to obtain a patient's identity in order to investigate anonymous complaints or to seek corroborating evidence. However, South Carolina's interest in obtaining patients' identifying information in those limited situations does not support the disclosure requirement in the Regulation, which gives the State access to information identifying *every* patient of *every* abortion clinic in the State. Such a disclosure requirement is vastly overbroad: in the apparent expectation that, someday, some of the information might be useful, it tramples the privacy interest of every woman who seeks an abortion at a South Carolina clinic.

In short, South Carolina has failed to demonstrate a compelling need for access to information identifying every patient of the abortion clinics in the State. As the district court properly recognized, the goals of the Disclosure Provision would be adequately served if the State is provided with access to *redacted* records. Memorandum of Decision, at 8-9. And in those limited instances where redacted records might be insufficient, the State has failed to narrowly tailor the Disclosure Provision to serve its interest in disclosure.

C.

In assessing whether the Disclosure Provision contravenes the right to informational privacy, we must also consider the probability of the unauthorized disclosure of the information collected by the State. *Walls,* 895 F.2d at 194; *see also Watson v. Lowcountry Red Cross,* 974 F.2d 482, 487-88 (4th Cir. 1992). Any safeguards designed by the State to prevent such improper disclosure serve to weaken a woman's privacy interest and reduce the need to prohibit South Caro-

lina from collecting the information in the first place. *Walls,* 895 F.2d at 194.

***17** In this case, the State has failed to show that it will protect the private medical information of female patients. To begin with, the statutes relied on by South Carolina do not erect an absolute bar to public disclosure of such information. *See* S.C. Code Ann. § 44-7-310 (West 2002);[8] S.C. Code Ann. § 44-7-315 (West 2002).[9] To the contrary, those statutes contain gaping holes in the protections they afford against public disclosure. For example, § 44-7-310 authorizes the public disclosure of identifying information during licensure proceedings. And § 44-7-315 *requires,* upon written request, the public disclosure of information obtained through inspection.

While § 44-7-315 serves to prohibit South Carolina from "disclos[ing] the identity of individuals present in a facility," it fails to explain what "present in a facility" is intended to mean. Under one interpretation, it might only protect the identity of persons present in the facility at the time records are released. Under another plausible interpretation, it could cover only those persons typically present in the facility — namely the permanent staff. And among other possible in-

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[8] Section 310, regarding "Certain information not to be disclosed publicly," states:

> Information received by the Office of Health Licensing ... may not be disclosed publicly in a manner as to identify individuals or facilities *except* in a proceeding involving the licensure or certification of need of the facility or licensing proceedings against an employee of the facility or as ordered by a court of competent jurisdiction.

S.C. Code Ann. § 44-7-310 (West 2002) (emphasis added).

[9] Section 315, titled "Disclosure of information regarding facility or home," reads, in pertinent part:

> Information received by the Division of Health Licensing ... *must be disclosed* publicly upon written request to the department.... The department *may not disclose the identity of individuals present in a facility* licensed by the department....

S.C. Code Ann. § 44-7-315 (West 2002) (emphasis added).

terpretations, it could mean that the identity of every person ever present in the facility may not be disclosed, which would include investigators and other State officials. In short, this ambiguous statutory language does not sufficiently ensure the confidentiality of the female patients of South Carolina abortion clinics.

Second, despite the State's assurances of confidentiality, private medical information has been leaked to the public. Although George Moore, the Director of Outpatient and Home Care in the Department of Health and Environmental Control ("DHEC"), testified that "strict confidentiality is maintained as it always is, records are secured in the office, and individual records are not released under Freedom of Information Act requests," South Carolina has failed to follow this directive. In point of fact, the evidence shows that abortion protesters distributed a flyer containing a photocopy of a medical record obtained from DHEC concerning a fifteen-year-old girl's pregnancy termination. Furthermore, physicians testified that similar types of confidential information collected by the State have been made available to the public.

D.

It is of significance, in assessing the validity of the Disclosure Provision, that the recordkeeping requirements established by South Carolina differ markedly from the types of data collection systems other courts have approved. For example, in *Whalen v. Roe,* 429 U.S. 589 (1977), the Supreme Court concluded that New York was constitutionally permitted to obtain and record, in a centralized computer file, the names and addresses of all persons who obtained, pursuant to a doctor's prescription, certain controlled substances for which there were both lawful and unlawful markets. *Id.* at 591-94. In that situation, New York provided elaborate security against the improper disclosure of private medical information, including storing the records in a receiving room surrounded by an alarmed and locked wire fence, and requiring destruction of the records after five years. *Id.* at

593-94. Further, the public disclosure of patients' identities was expressly prohibited by both a statute and an administrative regulation. *Id.* at 594-95.

***18** The situation in this case differs markedly from *Whalen* in at least three respects. First, as discussed above, *see supra* Part I.C., South Carolina's Disclosure Provision does not sufficiently ensure the confidentiality of private medical information. Second, the medical records of abortion patients differ in substance from the records collected in *Whalen.* In *Whalen,* the information compiled on drug use provided potentially incriminating evidence about the patients themselves, not just about the medical doctors who wrote the prescriptions. *Id.* at 592. Here, the private medical information sought by South Carolina is not for the purpose of investigating the female patients of abortion clinics. Rather, the State claims that such information will facilitate its investigations of the clinics providing abortion services.[10]

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[10] Where this Court has permitted a government entity to collect and maintain private information, the government interest has consistently related to the person whose privacy is at stake. *See Walls,* 895 F.2d at 192-93 (upholding data collection of police department applicants because of state interest in obtaining personal information of employees); *Hodge v. Jones,* 31 F.3d 157, 166 (4th Cir. 1994) (upholding data collection of reports of child abuse to aid future investigations of parents). The majority has unjustifiably extended these earlier decisions by now allowing South Carolina to collect patient information in order to investigate clinics.

In the only situation where the need to obtain private information related to a third party, the scope of the privacy invasion was narrowly tailored to the need for disclosure. In *Watson,* the plaintiff, who asserted a claim against a Red Cross donation center, was allowed to obtain discovery from an anonymous blood donor. 974 F.2d at 484. Thus, the interest in obtaining the information related to the Red Cross, while it was the donor whose privacy was compromised. However, in that case, only one donor's identity was at stake, and it was revealed only to the court. The trial court allowed the plaintiff to submit questions to counsel for the anonymous donor, but the identities of the donor and the donor's counsel were known only to the court. *Id.* at 484, 487. In contrast, the South Carolina Regulation provides the State with access to *every* patient record without any judicial supervision on how the information is used.

Finally, the plaintiffs in *Whalen* claimed to fear the disclosure of their medical records because of the stigma attached to the use of controlled substances. *Id.* at 595 n. 16. In this case, women seeking abortions in South Carolina have a great deal more to fear than stigma. The protests designed to harass and intimidate women entering abortion clinics, and the violence inflicted on abortion providers, provide women with ample reason to fear for their physical safety. *See Thornburgh,* 476 U.S. at 767 n. 12.

For these reasons, the identifying information contained in medical records of women seeking services at abortion clinics in South Carolina must be kept confidential. The majority, in my view, is entirely unable to justify South Carolina's broad access to unredacted records, and it has not shown that the purported safeguards ameliorate privacy concerns. In sum, the Disclosure Provision violates the constitutionally protected right of informational privacy, and the majority is incorrect to conclude otherwise.

II.

I also disagree with the majority on the constitutionality of § 307 of the Regulation (the "Consultation Provision").[11] The Plaintiffs maintain that the Consultation Provision unconstitutionally compels South Carolina abortion clinics to form professional affiliations with members of the clergy and entangles the State in religious matters.[12] The majority, on

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[11] The Consultation Provision of the Regulation, found in § 307, requires that:

> Arrangements shall be made for consultation or referral services in the specialties of obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, *clergy,* and social services, as well as any other indicated field, to be available as needed.

24 S.C. Code Ann. Regs. 61-12, § 307 (Cum. Supp. 2001) (emphasis added).

[12] Plaintiffs also contend that the Consultation Provision improperly gives religious leaders veto authority over the issuance of abortion licenses. Because I would find that the Provision violates the Establish-

the other hand, views the Plaintiffs' concerns as "grounded on a substantial misreading of § 307, imputing obligations and relationships that are not prescribed by the regulation." *Ante* at 10. Specifically, the majority believes that "[t]hese arrangements might amount to no more than a list of clergy and other specialists or a readily accessible telephone book to consult as required by the needs of a particular patient," and that no arrangement for religious counseling need be made until a patient requests the referral. *Ante* at 10-11.

In concluding that the Consultation Provision complies with the Establishment Clause, the majority interprets the clergy referral requirement in a plainly implausible way. Under a reasonable interpretation of the Consultation Provision, abortion providers in South Carolina must establish professional affiliations with members of the clergy in order to ensure that religious consultation and referral services will be available to their female patients. And to enforce this Provision, the State inevitably must establish and enforce religious criteria. Because the Establishment Clause[13] precludes South Carolina from becoming entangled with religion in this way, the Consultation Provision is unconstitutional.

A.

***19** In South Carolina, duly promulgated state regulations, like statutes, are to "receive practical, reasonable and fair interpretation consonant with the purpose, design and policy of lawmakers." *Whiteside v. Cherokee County*

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ment Clause in excessively entangling the State with religious counseling, I would not reach the issue of whether the Consultation Provision might also give religious leaders too much authority over government functions. *See generally Larkin v. Grendel's Den, Inc.*, 459 U.S. 116 (1982). I do, however, address a similar contention in dealing with the Regulation's improper delegation of state authority. *See infra* Part IV.

[13] The Establishment Clause provides that "Congress shall make no law respecting an establishment of religion." U.S. CONST. amend. 1. It has been incorporated against the states through the Fourteenth Amendment. *Zelman v. Simmons-Harris*, 534 U.S. ----, 122 S. Ct. 2460, 2465 (2002); *Everson v. Bd. of Educ. of Ewing Township*, 330 U.S. 1, 15-16 (1947).

Sch. Dist. No. 1, 428 S.E.2d 886, 888 (S.C. 1993). Viewed in this way, the express terms of the Consultation Provision cannot support the majority's strained interpretation; the Provision unequivocally requires clinics to establish prearrangements for consultation services with members of the clergy. Although the services must be "available as needed," the arrangements plainly must be made before a clinic can obtain a license. Moreover, the "arrangement" requirement of the Consultation Provision indicates that abortion providers must do more than merely make a telephone book available to their female patients. Indeed, for a female patient to have access to specialists in the fields specified in the Consultation Provision, such as anesthesiology or surgery, a telephone book would not be particularly helpful. And the majority gives no reason why the mandated "arrangements" with members of the clergy should be treated differently.

Further, the majority's interpretation of the Consultation Provision inexplicably ignores the explicit intent of the South Carolina official who wrote the Regulation. According to Mr. Moore, the Director of Outpatient and Home Care in the Division of Licensing of DHEC, and the state official who drafted the Regulation, clinics must make *prearrangements* for consultation.[14] In fact, Mr. Moore testified that prior arrangements are required with "maybe two or three different denominations just to be on call." Although "[i]t probably

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[14] In general, an agency's interpretation of its own regulation deserves considerable deference. *See Brown v. S.C. Dep't of Health & Envtl. Control,* 560 S.E.2d 410, 415 (S.C. 2002). Although a position taken in litigation (which is one way Mr. Moore's view could be characterized) may be treated differently, a policy statement should be given deference where it reflects the considered and reasoned judgment of the agency, rather than a post hoc rationalization of an enforcement decision. *See Monongahela Power Co. v. Reilly,* 980 F.2d 272, 279 (4th Cir. 1993). Mr. Moore's testimony therefore is entitled to consideration in assessing what the Consultation Provision requires. Further, because South Carolina inspectors have broad discretion to determine what might violate the Consultation Provision, abortion providers would be well advised to heed DHEC's warning on how the law will be enforced.

wouldn't be a Catholic priest," Mr. Moore opined that they "would just have to have Protestant and whatever else." Given the plain terms of the Consultation Provision and the unequivocal statements of its drafter, abortion providers in South Carolina must, in order to comply with the Provision, do more than merely provide their patients with a telephone book. *Ante* at 10.

B.

It is with this interpretation of the clergy referral requirement in mind that I turn to an assessment of the constitutionality of the Consultation Provision. In order to determine whether a regulation violates the Establishment Clause, we must apply the three-prong test that the Supreme Court articulated in *Lemon v. Kurtzman,* 403 U.S. 602 (1971). First, the regulation must have a secular purpose. Second, the primary effect of the regulation must neither advance nor inhibit religion. And third, the regulation must not foster an excessive government entanglement with religion. *Id.* at 612-13. As explained below, the Consultation Provision clearly violates *Lemon's* third prong, and it probably contravenes the second prong as well.

1.

The first prong of the *Lemon* test presents a fairly low hurdle for the State. *Brown v. Gilmore,* 258 F.3d 265, 276 (4th Cir.), *cert. denied,* 122 S. Ct. 465 (2001). Here, the Consultation Provision appears to have a secular purpose. The State promulgated it for the ostensible purpose of protecting maternal health and to ensure that women seeking abortion services have access to experts in a range of specialty fields. The first prong of *Lemon* contemplates an inquiry into the subjective intentions of the government. *See Wallace v. Jaffree,* 472 U.S. 38, 56 (1985) ("[I]t is appropriate to ask 'whether government's actual purpose is to endorse or disapprove of religion.'") (quoting *Lynch v. Donnelly,* 465 U.S. 668, 690 (O'Connor, J., concurring)). Without more

evidence of a religious purpose, the Consultation Provision survives the first prong of the *Lemon* test.

2.

***20** By contrast, the Consultation Provision in all likelihood fails *Lemon's* second prong. This prong's "primary effect" test requires an objective assessment, rather than a subjective one, and it measures whether the principal effect of government action "is to suggest government preference for a particular religious view or for religion in general." *Barghout v. Bureau of Kosher Meat & Food Control,* 66 F.3d 1337, 1345 (4th Cir. 1995). Here, the Consultation Provision compels physicians providing abortion services to establish affiliations with religious institutions. This mandatory affiliation seems to convey the message that the State endorses the beliefs of the religious counselors. Further, the clergy referral requirement appears to promote the religious mission of those institutions given referral arrangements.[15] Under our Constitution, however, the government is not permitted to sponsor the indoctrination of religious beliefs in this manner.

More disturbingly, South Carolina has indicated it will play favorites among religions in enforcing the Consultation

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[15] Unlike those situations where courts have permitted religious groups to provide state-sponsored counseling services, the message of the clergy in this case is purely religious. Further, the counseling services here *must* be provided by pervasively sectarian organizations. South Carolina is not merely allowing religious groups to participate on an equal basis in grant programs; it has facilitated religious indoctrination. In *Bowen v. Kendrick,* 487 U.S. 589 (1988), the Supreme Court held that religious groups could receive funds from the government in order to counsel teenagers regarding adolescent sexual relations. However, the counseling services were not inherently religious, the grant program directed that the money should be spent for secular purposes, and the groups providing counseling services were not pervasively sectarian. *See id.* at 604-05 ("The services to be provided under the AFLA are not religious in character, nor has there been any suggestion that religious institutions or organizations with religious ties are uniquely well qualified to carry out those services.") (internal citation omitted); *see also id.* at 610-12.

Provision.[16] The interpretation given to this Provision by DHEC's Division of Licensing unquestionably violates the hallmark of the Establishment Clause, which is that the government must be neutral with respect to different religious beliefs. According to Mr. Moore, referral arrangements with members of the clergy must include at least one Protestant minister, and they need not include a Catholic priest. This governmental preference for certain religious beliefs violates what Judge Luttig has characterized as "the most fundamental tenet of the Establishment Clause [which] is that the imprimatur of the state shall not directly or indirectly be placed upon one religious faith over another." *Id.* at 1346 (Luttig, J., concurring). Given these defects, the Consultation Provision almost certainly contravenes the second prong of the *Lemon* test.

3.

In any event, the Consultation Provision surely fails the third prong of the *Lemon* test, because it excessively entangles the State with religion. Under *Lemon's* final prong, the Court requires that we analyze "the character and purposes of the institutions that are benefited, the nature of the aid that the State provides, and the resulting relationship between the government and religious authority." *Lemon,* 403 U.S. at 615. In this case, the benefited institutions are quintessentially religious. Unlike the religious groups that have elsewhere been allowed to participate in government programs, the institutions that receive the benefit of referral arrange-

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[16] If the Consultation Provision is enforced in a manner where certain religions are actually favored, as Mr. Moore suggests, it should be enjoined without applying the *Lemon* analysis. *Larson v. Valente,* 456 U.S. 228, 252 (1982) ("[T]he *Lemon v. Kurtzman* 'tests' are intended to apply to laws affording a uniform benefit to *all* religions, and not to provisions ... that discriminate *among* religions."); *see also County of Allegheny v. ACLU Greater Pittsburgh Chapter,* 492 U.S. 573, 604 (1989) ("Whatever else the Establishment Clause may mean ... it certainly means at the very least that government may not demonstrate a preference for one particular sect or creed.").

ments under the Consultation Provision are pervasively sectarian. By virtue of the Consultation Provision, churches in South Carolina have been given additional opportunities to proselytize; female patients of abortion providers will now be referred to a preacher at the direction of the State. Such a referral requirement is unprecedented, and it should be recognized as unconstitutional.

***21** Further, the State's enforcement of the Consultation Provision will inevitably entangle the State in religious counseling. DHEC inspectors and bureaucrats must determine not only whether the mandated clergy referral arrangements have been made, but also whether the arrangements with members of the clergy satisfy criteria that are necessarily religious. To enforce the Consultation Provision, the State must inquire into who qualifies as an appropriate member of the "clergy," and it must decide whether the referral arrangements are sufficient to meet the religious needs and preferences of female patients. In requiring DHEC inspectors to determine whether abortion providers have complied with these religious requirements, the Consultation Provision excessively entangles the State in religious indoctrination. As such, it violates the Establishment Clause, and it should be invalidated.

III.

While I agree with the majority that most of the challenged aspects of the Regulation are sufficiently clear to withstand a constitutional vagueness analysis,[17] I see two of those provisions as unconstitutionally vague. First, the inspectors for South Carolina have unbridled discretion to decide whether an abortion provider in that State has somehow deviated from an amorphous "best practices" requirement, which is found both in Chapter 10 and § 103 of the Regulation (the "Best Practices Provisions"). *See* 24 S.C. Code

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[17] In particular, I agree that §§ 102(J), 102(L), 201(B), 204, 205(C)(1), 301, 306-308, 501(A), 602(A), 604, 606, and 807 of the Regulation are not unconstitutionally vague.

Ann. Regs. 61-12, Chapter 10 (Cum. Supp. 2001); 24 S.C. Code Ann. Regs. 61-12, § 103(C) (Cum. Supp. 2001).[18] Second, under a particularly incomprehensible section, abortion clinics in South Carolina must arrange for local hospital admitting privileges for either some or all of their staffs. However, exactly which staff members are required to possess such privileges is inherently ambiguous because of an unfortunately placed "and/or" connector found in § 305 of the Regulation (the "And/Or Provision"). *See* 24 S.C. Code Ann. Regs. 61-12, § 305(A) (Cum. Supp. 2001).[19] The majority unjustifiably and incorrectly ignores the fundamental vagueness of these Provisions.

The Due Process guarantee of the Fourteenth Amendment prohibits state statutes and regulations that are "so vague that men of common intelligence must necessarily guess at [their] meaning and differ as to [their] application." *Smith v. Goguen,* 415 U.S. 566, 572 n. 8 (1974) (quoting *Connally v. Gen. Constr. Co.,* 269 U.S. 385, 391 (1926)). Further, such statutes and regulations may not be so vague

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[18] Chapter 10 of the Regulation provides: "Conditions arising that have not been addressed in these regulations shall be managed in accordance with the best practices as interpreted by the Department." 24 S.C. Code Ann. Regs. 61-12, Chapter 10 (Cum. Supp. 2001). Section 103(C) similarly states that "Class III violations are those that are not classified as Class I or II in these regulations or those that are against the best practices as interpreted by the Department." 24 S.C. Code Ann. Regs. 61-12, § 103(C) (Cum. Supp. 2001). The majority concentrates on Chapter 10 in discussing the "best practices" requirement. *Ante* at 16. However, because Chapter 10 and § 103(C) contain the same "best practices" language, I refer to them collectively as the "Best Practices Provisions."

[19] Section 305(A) of the Regulation reads:

> All staff *and/or* consulting physicians shall have admitting privileges at one or more local hospitals that have appropriate obstetrical/gynecological services or shall have in place documented arrangements approved by the Department for the transfer of emergency cases when hospitalization becomes necessary.

24 S.C. Code Ann. Regs. 61-12, § 305(A) (Cum. Supp. 2001) (emphasis added).

that they invite arbitrary and discriminatory enforcement. *Kolendar v. Lawson,* 461 U.S. 352, 357 (1983); *see also Papachristou v. City of Jacksonville,* 405 U.S. 156, 162 (1972) (invalidating an ordinance on vagueness grounds partially because it encouraged "arbitrary and erratic arrests and convictions"); *see generally City of Chicago v. Morales,* 527 U.S. 41, 56 (1999) (plurality); *Grayned v. City of Rockford,* 408 U.S. 104, 108-09 (1972).

A.

***22** In order to be consistent with the requirements of due process, statutes and regulations with criminal sanctions must achieve a higher level of clarity than those which provide for civil penalties only. *Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc.,* 455 U.S. 489, 498-99 (1982) ("The Court has also expressed greater tolerance of enactments with civil rather than criminal penalties because the consequences of imprecision are qualitatively less severe."). While the majority acknowledges this principle, it inexplicably and incorrectly assumes that violations of the Regulation carry civil penalties only. *Ante* at 4, 16. On the contrary, a violation of the general licensing article of the South Carolina Code, which applies specifically to health care facilities providing abortion services to women in South Carolina, constitutes a misdemeanor criminal offense. S.C. Code Ann. § 44-7-340 (West 2002). In order to be constitutional, the Regulation's licensing scheme must therefore be analyzed under the standard of clarity applicable to criminal offenses.

Further, even if criminal penalties were not implicated, the Regulation threatens the exercise of constitutionally protected rights. For this reason alone, it must achieve a heightened level of precision. *Colautti v. Franklin,* 439 U.S. 379, 391, 394 (1979) (noting that regulations that threaten abortion rights are held to a higher level of clarity). Indeed, the constitutionally protected right to seek an abortion has been treated with such hostility that abortion providers are uniquely susceptible to being targeted by arbitrary and dis-

criminatory enforcement. *Women's Med. Ctr. of Northwest Houston v. Bell,* 248 F.3d 411, 422 (5th Cir. 2001) ("Especially in the context of abortion, a constitutionally protected right that has been a traditional target of hostility, standardless laws and regulations ... open the door to potentially arbitrary and discriminatory enforcement."). Given the fact that the South Carolina licensing scheme threatens criminal penalties, and in light of the additional fact that constitutionally protected rights are at stake, the provisions of the Regulation must be especially clear as to what is required and what is prohibited.

B.

1.

The majority candidly concedes that the "best practices" requirement makes Chapter 10 the "most unclear provision in Regulation 61-12." *Ante* at 16. Under the Best Practices Provisions, a South Carolina abortion provider must comply with "best practices as interpreted by the Department." 24 S.C. Code Ann. Regs. 61-12, Chapter 10 (Cum. Supp. 2001); 24 S.C. Code Ann. Regs. 61-12, § 103(C) (Cum. Supp. 2001). Despite recognizing that the Best Practices Provisions lack clarity, the majority fails to subject them to a vagueness analysis. The proper answers to two questions dispose of the issue: Would a person of reasonable intelligence understand what is required by the Best Practices Provisions? The answer is "No." Is the language of these Provisions so standardless that it enables arbitrary and discriminatory enforcement? The answer is "Yes."

***23** The majority seems to rely, inappropriately, on a reading of the Regulation "in its entirety" in deciding to uphold the Best Practices Provisions. *Ante* at 15. The Supreme Court, however, has recently demonstrated that overbreadth and vagueness analyses are to be conducted on a provision-by-provision basis. *See Ashcroft v. Free Speech Coalition,* 534 U.S. ---, 122 S. Ct. 1389, 1405-06 (2002) (analyzing

different provisions of the Child Pornography Prevention Act separately and concluding that only certain subsections violated the First Amendment). Standing alone, the Best Practices Provisions contained in Chapter 10 and § 103 of the Regulation offer no guidance on the scope of their coverage, and they are therefore unconstitutionally vague.

2.

The And/Or Provision found in § 305(A) of the Regulation, as the majority acknowledges, is also "inherently ambiguous." *Ante* at 12. This Provision requires that "[a]ll staff *and/or* consulting physicians shall have admitting privileges at one or more local hospitals." 24 S.C. Code Ann. Regs. 61-12, § 305(A) (Cum. Supp. 2001) (emphasis added). Because of the "and/or" connector, abortion providers in South Carolina, who are subject to criminal sanctions if they violate the Regulation, lack sufficient notice as to what is required of them. *Cf. United States v. Bush,* 70 F.3d 557, 562 (10th Cir. 1995) (discussing the inherent vagueness of an indictment with an "and/or" connector). On the one hand, the And/Or Provision might require all staff physicians and all consulting physicians to have admitting privileges at local hospitals. On the other hand, it might require either all staff physicians or all consulting physicians to have admitting privileges. To add to the confusion, the word "staff" in this Provision could be functioning either as a noun or as an adjective. If it is a noun, it is possible to read the And/Or Provision to require that the receptionist, at every abortion clinic in the State, possess admitting privileges.

3.

In sum, neither the Best Practices Provisions nor the And/Or Provision set forth a sufficiently ascertainable standard of conduct to provide the abortion providers in South Carolina with proper notice of their scope. Therefore, we should hold each of these Provisions to be unconstitutionally vague.

IV.

Finally, the majority errs in ruling that the Regulation's delegation of decisionmaking authority over abortion licensing complies with due process requirements. Several parts of the Regulation give private parties authority over the licensing of abortion providers in South Carolina. These provisions include: § 205(C)(2),[20] § 305(A),[21] and § 309(B)[22] (collectively, the "Hospital Privilege Provisions"), as well as the Consultation Provision. Because these Provisions give private parties unguided power to refuse to affiliate with abortion clinics, they should be recognized as unconstitutional delegations of government licensing authority.

***24** Because the licensing scheme spelled out in the Regulation threatens to deprive abortion providers in South Carolina of a protected property interest and to burden the liberty interest of women seeking abortions, it must comport with due process. The Due Process Clause requires licensing decisions to be based upon established standards, rather than upon the whim or caprice of the licensor. *Yick Wo v. Hopkins,* 118 U.S. 356, 370 (1886); *see also GE Co. v. N.Y. State Dep't of Labor,* 936 F.2d 1448, 1454-55 (2nd Cir. 1991); *Hornsby v. Allen,* 326 F.2d 605, 608 (5th Cir. 1964). And if

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20 Section 205(C)(2) of the Regulation provides:

> The facility shall enter into a signed written agreement with at least one physician board-certified in obstetrics and gynecology (if not one on staff) who has admitting privileges at one or more local hospitals with OB/GYN services to ensure his/her availability to the staff and patients during all operating hours.

24 S.C. Code Ann. Regs. 61-12, § 205(C)(2) (Cum. Supp. 2001).

21 I have previously designated § 305(A) of the Regulation as the "And/Or Provision." *See supra* Part III. It is also one of the Hospital Privilege Provisions implicated in the improper delegation challenge to the Regulation's hospital admitting privilege requirements.

22 Section 309(B) of the Regulation provides: "Physicians shall have admitting privileges at one or more local hospitals that have appropriate obstetrical/gynecological services." 24 S.C. Code Ann. Regs. 61-12, § 309(B) (Cum. Supp. 2001).

a state decides to delegate part of its licensing authority to a third party, that authority must be exercised in a manner that is consistent with due process requirements. *Hallmark Clinic v. N.C. Dep't of Human Res.*, 380 F. Supp. 1153, 1158-59 (E.D.N.C. 1974) (three-judge panel), *aff'd in part on other grounds*, 519 F.2d 1315 (4th Cir. 1975).

The Plaintiffs maintain that several provisions of the Regulation constitute an improper delegation, without sufficient standards, of the State's licensing authority. Specifically, the Plaintiffs challenge the mandate of the Hospital Privilege Provisions that physicians (and/or others) possess admitting privileges at local hospitals, and they challenge the Consultation Provision's referral arrangement requirement. The Plaintiffs maintain that these provisions grant hospitals and medical specialists, as well as members of the clergy, an effective "veto power" over the licensing of abortion providers. The State, on the other hand, does not contend that the Regulation provides any standards or guidelines for when, or under what circumstances, third parties may refuse to affiliate with abortion providers. It relies, instead, on the irrelevant fact that such providers have not yet had difficulty obtaining licenses.

In rejecting the Plaintiffs' delegation challenges, it is striking that the majority fails to address two contrary decisions directly on point. Indeed, a three-judge district court in this Circuit concluded that a state may not constitutionally delegate to hospitals the unbridled control over abortion licensing by conditioning a license on hospital admitting privileges. In *Hallmark Clinic*, Judge J. Braxton Craven, Jr., then a distinguished member of this Court from North Carolina, addressed the very question we face today, and the majority takes issue with his reasoning without mentioning his considered opinion.[23] In that case, Hallmark Clinic chal-

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[23] The *Hallmark Clinic* panel was convened pursuant to a statute, since repealed, that required a special three-judge court to hear and decide claims seeking to enjoin the enforcement of a state statute on constitu-

lenged a North Carolina licensing scheme that required abortion providers to have transfer agreements with local hospitals. 380 F. Supp. at 1156. Because the challenged North Carolina regulation did not limit the discretion of hospitals to decide whether to grant such privileges, the court held that the regulation constituted an unconstitutional delegation. As Judge Craven concluded, "the state cannot confer upon a private institution the exercise of arbitrary and capricious power." *Id.* at 1159. If a state requires that physicians have admitting privileges in hospitals in order to obtain licenses to perform abortions, "it must establish and enforce standards for admission to hospital staff privileges." *Id.* Here, South Carolina, like North Carolina in the 1970s, has "given hospitals the arbitrary power to veto the performance of abortions for any reason or no reason at all. The state cannot grant hospitals power it does not have itself." *Id.* at 1158-59.

***25** In *Birth Control Centers, Inc. v. Reizen,* 508 F. Supp. 1366 (E.D. Mich. 1981), *aff'd in part and vacated in part on other grounds,* 743 F.2d 352 (6th Cir. 1984), a district court in Michigan invalidated a regulation similar to the North Carolina licensing scheme at issue in *Hallmark Clinic.* There, Michigan had promulgated a regulation requiring abortion providers to obtain transfer agreements with local hospitals before they could obtain a license. *Id.* at 1369. Relying on the *Hallmark Clinic* decision, the court struck down the Michigan regulation as an impermissible delegation of state power. *See id.* at 1374 (holding that hospital privilege requirements "violate due process concepts because they delegate a licensing function to private entities without standards to guide their discretion"); *see also GE Co. v. N.Y. State Dep't of Labor,* 936 F.2d at 1455 ("[A] legislative body may not constitutionally delegate to private parties the power

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tional grounds. *See* 28 U.S.C. § 2281 (repealed 1976). While *Hallmark Clinic* may not constitute binding authority in our Circuit, Judge Craven's well-reasoned opinion, in the absence of other controlling precedent, should be considered persuasive authority and accorded great weight.

to determine the nature of rights to property in which other individuals have a property interest, without supplying standards to guide the private parties' discretion.").

Because the Hospital Privilege Provisions of the Regulation delegate the unfettered power to control the licensing of abortion providers, they violate the Due Process Clause. *See Danforth,* 428 U.S. at 74 ("[T]he State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of the reason for withholding consent."). In addition to other constitutional infirmities, the Hospital Privilege Provisions and the Consultation Provision (for the same reasons that apply to the Hospital Privilege Provisions) constitute standardless delegations of state power. As such, they violate the Due Process Clause and should be invalidated.

V.

In sum, the majority has misapprehended the underlying facts and misapplied the applicable law in upholding the Regulation in its entirety. Under an appropriate construction of the Regulation and an application of controlling legal principles, several of its provisions are unconstitutional. In particular, the Disclosure Provision violates the right to informational privacy; the Consultation Provision contravenes the Establishment Clause (as well as the Due Process Clause in improperly delegating state licensing authority); the And/Or Provision and the Best Practices Provisions are unconstitutionally vague; and the Hospital Privilege Provisions violate due process by unconstitutionally delegating state licensing authority.

Because the majority refuses to recognize these constitutional infirmities, I respectfully dissent.

2002 WL 31928629 (4th Cir. (S.C.))

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

Greenville Women's Clinic, Charleston Women's Clinic, Inc., and William Lynn, M.D., on behalf of themselves and their patients seeking abortions,	) CA No. 6:96-1898-20
Plaintiffs,	) MEMORANDUM OF DECISION
vs.	
Douglas E. Bryant, in his official capacity as Commissioner of South Carolina Department of Health and Environmental Control, Governor of the State of South Carolina, and Charles M. Condon, in his official capacity as Attorney General of the State of South Carolina,	
Defendants.	

This matter is before the court on the briefs of the parties. The plaintiffs challenge the constitutionality of South Carolina Code Annotated Regulation 61-12 ("Regulation 61-12"). The court now declares its findings of fact and conclusions of law in accordance with Rule 52 of the Federal Rules of Civil Procedure. Should a finding of fact constitute a conclusion of law, or vice versa, the court adopts it as such and directs that it be treated accordingly.

I. FINDINGS OF FACT

1. The Greenville Women's Clinic ("GWC") is a medical practice in Greenville owned and operated by Drs. Buffkin and Campbell. (Stip. Facts ¶ 2.)

3. Dr. Lynn owns and operates a medical practice in Greenville called the Palmetto State Medical Clinic ("PSMC"). (Stip. Facts ¶ 3.)

4. Drs. Buffkin, Campbell, and Lynn are all licensed to practice medicine in South Carolina. (Stip. Facts ¶ 1.)

5. GWC and PSMC provide a range of gynecological services, including first-trimester, suction curettage abortions. (Stip. Facts ¶ 4.)

6. GWC also provides first-trimester medical abortions. (Stip. Facts ¶ 5.)

7. Both the GWC and Dr. Lynn perform over five abortions each month and well over sixty abortions per year. (Stip. Facts ¶ 6.)

8. Prior to the court's July 9, 2001, injunction, all abortion clinics in the state were licensed. (Stip. Facts ¶ 7.)

9. Drs. Buffkin and Campbell of the GWC have admitting privileges at Greenville-area hospitals. (Stip. Facts ¶ 8.)

10. Although Dr. Lynn does not have admitting privileges at a Greenville-area hospital, he does have a written transfer agreement with a local doctor who does have admitting privileges. Dr. Lynn also has admitting privileges at a Beaufort-area hospital. (Stip. Facts ¶ 9, 10.)

11. On July 27,1996, the plaintiffs filed suit seeking declaratory judgment that Regulation 61-12 was facially unconstitutional. (Compl.) Specifically, the complaint alleged that Regulation 61-12 was unconstitutional because it: (1) denied the plaintiffs equal protection of the laws; (2) deprived the plaintiffs of their right to privacy; (3) was void for vagueness; (4) violated the plaintiffs' right to due process by delegating veto power over facility licensing to third parties; (5) violated the Establishment Clause; and (6) intruded on patients' rights to confidentiality in their medical records. After a six-day bench trial, United States District Judge William B. Traxler, Jr., held that Regulation 61-12 was unconstitutional based on the plaintiffs' first two grounds. Judge Traxler did not reach the four remaining claims.

12. On August 15, 2000, the United States Court of Appeals for the Fourth Circuit reversed the district court's ruling. See Greenville Women's Clinic v. Bryant, 222 F.3d 157, 175 (4th Cir. 2000).

13. The plaintiffs subsequently requested a hearing *en banc* which was denied. On February 26, 2001, the United States Supreme Court denied certiorari. See Greenville Women's Clinic v. Bryant, 121 S. Ct. 1188 (2001).

14. Following the Supreme Court's denial of certiorari, the plaintiffs requested and the court granted a 120-day preliminary injunction to allow the plaintiffs to come into compliance with Regulation 61-12. In addition, the parties briefed the issue of whether there were any remaining claims. On June 26, 2001, the court held that because the Fourth Circuit had failed to remand the case to the district court the case had ended. See Greenville Women's Clinic v. Bryant, No, 6:96-1989 (D.S.C. June 26, 2001).

15. The plaintiffs appealed this ruling to the Fourth Circuit and the case was remanded to the district court to determine issues preserved but not decided by earlier opinions. See Greenville Women's Clinic v, Bryant, No. 01-1856 (4th Cir. July 5, 2001). On July 9, 2001, the court granted the plaintiffs a preliminary injunction pending the outcome of the remaining claims.

II. CONCLUSIONS OF LAW

The court has jurisdiction based on the presence of a federal question pursuant to 28 U.S.C. § 1331. Venue in this judicial district is appropriate based on 28 U.S.C. § 1391(b). The plaintiffs make a facial challenge to Regulation 61-12 on four grounds, alleging that the regulation is unconstitutional because it (1) is void for vagueness; (2) violates the plaintiffs' right to due process by delegating veto power over facility licensing to third parties; (3) violates the Establishment Clause; and (4) intrudes on patients' rights to confidentiality in their medical records.

A. Vagueness

The plaintiffs assert that Regulation 61-12 is unconstitutionally vague. "A statute can be impermissibly vague for either of two independent reasons. First, if it fails to provide people of ordinary intelligence a reasonable opportunity to understand what conduct it prohibits. Second, if it authorizes or even encourages arbitrary and discriminatory enforcement." Hill v. Colorado, 530 U.S. 703, 732 (2000). "[S]peculation about possible vagueness in hypothetical situations not before the Court will not support a facial attack on a statute when it is surely valid 'in the vast majority of its intended applications.'" Id. at 733 (quoting United States v. Raines, 362 U.S. 17, 23 (1960)). A statute can never be held to mathematical certainty. See id. A statute is not vague because "difficulty is found in determining whether certain marginal offenses fall within [its] language." United States v. National Dairy Prods. Cor., 372 U.S. 29, 32 (1963). The plaintiffs cite a litany of phrases which are allegedly unconstitutionally vague. After review of the sections and taking the Regulation 61-12 as a whole, the court finds that people of ordinary intelligence would be able to understand what the regulation requires, and that the statute does not encourage arbitrary and discriminatory enforcement. In fact, it appears that the majority of the Regulation 61-12 is identical to the American College of Obstetricians and Gynecologists' ("ACOG") standards for obstetricians and gynecologists. See Bryant, 222 F.3d at 167 ("Regulation 61-12 largely tracks [the ACOG] medical standards and guidelines.") Therefore, the court finds that the plaintiffs' constitutional challenge to Regulation 61-12 on this ground must fail.

B. Unlawful Delegation of Veto Power

The plaintiffs allege that Regulation 61-12 should be stricken because it allows for the unconstitutional delegation of veto power to a third party. Specifically, the plaintiffs assert that members of the public, i.e. local clergy, doctors, and hospitals, have the ability to prevent a clinic from becoming

licensed.[1] The plaintiffs rely on Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) for the proposition that the government cannot give a third party absolute veto power over abortion decisions. See 428 U.S. at 74. In Danforth, the Court struck down a statute which required a spouse's consent or parental consent for a minor before a woman could obtain an abortion. As support for its conclusion, the Court cited Eisenstadt v. Baird, 405 U.S. 438 (1972) which established that "[i]f the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." 405 U.S. at 453 (emphasis in original). While Regulation 61-12 may affect a woman's selection of an abortion facility, it does nothing to impede an individual woman's right to choose to have an abortion.

The constitutional challenge put forth by the plaintiffs regarding the veto argument has nothing to do with a woman's constitutional right to have an abortion. Instead, the plaintiffs are concerned with the potential that they will be deprived of a property interest without being afforded due process under the fourteenth amendment. The plaintiffs, however, have failed to demonstrate that physicians would not be afforded due process in obtaining hospital privileges. Therefore, the plaintiffs' challenge to Regulation 61-12 on this ground must fail. See generally Women's Health Center of West County, Inc. v. Webster, 871 F.2d 1377 (8th Cir. 1989) (statute requiring physician performing abortions to have attending privileges at a hospital held constitutional);

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[1] Regulation 61-12 requires that a clinic have attending privileges or a transfer agreement with a local hospital and have an arrangement for consultation and referral services in the specialities of obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, clergy, and social services, as well as any other indicated field, to be available as needed. See S.C. Code Ann. Reg. 61-12 §§ 205(C)(2), 305(A), & 307.

but see Birth Control Ctrs., Inc. v. Reizen, 508 F. Supp. 1366 (E.D. Mich. 1981), aff'd in part, vacated in part, 743 F.2d 352 (6th Cir. 1984) (invalidating requirement that clinic have transfer agreement with hospital); Hallmark Clinic v. North Carolina Dep't of Human Res., 380 F. Supp. 1153 (E.D.N.C. 1974) (holding that requirement that clinics have written agreements with hospitals for patient access was unconstitutional).

C. Establishment Clause

The plaintiffs assert that Regulation 61-12 violates the Establishment Clause of the United States Constitution. To pass constitutional muster with regard to the Establishment Clause, (1) the statute must "have a secular purpose"; (2) its "principal or primary effect must be one that neither advances nor inhibits religion"; and (3) "the statute must not foster 'an excessive government entanglement with religion.'" Lemon v. Kurtzman, 403 U.S. 602, 612-13 (1971) (quoting Walz v. Tax Comm'n, 397 U.S. 664, 674 (1970)). "The endorsement test does not preclude government from acknowledging religion or from taking religion into account in making law and policy." Wallace v. Jaffree, 472 U.S. 38, 69 (1985) (O'Connor, J., concurring). The plaintiffs assert that Regulation 61-12 violates the Establishment Clause in two ways. First, because the statute requires that the clinic have clergy available for counseling and second, because the regulation delegates veto power to a religious entity. The court finds these arguments unpersuasive.

First, as to the requirement that the clinic have clergy available for counseling, the plaintiffs have not asserted nor does the court find that Regulation 61-12 has a non-secular purpose. The purpose of the statute is to safeguard the health of women seeking abortions. See Greenville Women's Clinic v. Bryant, 222 F.3d 157, 168 (4th Cir. 2000). Nor is the primary effect of this portion of the regulation to advance or inhibit religion. The regulation does not require a patient to undergo religious counseling. It simply requires that such

counseling be available if needed. The court does not see how the availability of religious counseling advances or inhibits religion. Finally, the statute does not foster an "excessive" government entanglement with religion. See Lemon, 403 U.S. at 612-13. While the requirement itself is religious in nature, it does not require that the functions of government and religion become intertwined. Because the regulation only requires third parties, not state officials, to provide for the availability of religious counseling, it is a far cry from an excessive entanglement.

As to the assertion that the regulation impermissibly delegates veto power to a religious entity thereby violating the Establishment Clause, the plaintiffs rely on Larkin v. Grendel's Den, Inc., 459 U.S. 116 (1932) and Board of Education of Kiryas Joel Village School District v. Grumet, 512 US. 687 (1994). In Larkin, a Massachusetts statute gave governing bodies of schools and churches the power to prevent the issuance of a liquor license for premises within five hundred feet of a church or school. The Supreme Court held that this statute violated the Establishment Clause. In Kiryas Joel, a state school district carved out a special school district for a village which consisted exclusively of practitioners of a strict form of Judaism. The Supreme Court held that this district improperly allocated political power to a religious group. These cases are distinguishable from the case at bar.

First, Regulation 61-12 does not vest the power to prevent the issuance of a license to any one person or entity. In Larkin, a single school or church could prevent the issuance of a liquor license. In this case, there would be multiple opportunities for a clinic to find clergy members who are willing to be available for counseling. As to Kiryas Joel, the religious group was essentially vested with enormous authority to run a public school in accordance with religious beliefs. That is quite different from requiring a medical clinic to have religious counselors available. Also, as stated above, the regulation has a secular purpose, does not promote or inhibit

religion, and does not excessively entangle the government with religion. See Lemon, 402 U.S. at 612-13. For these reasons, the court finds that Regulation 61-12 does not offend the Establishment Clause.

D. Informational Privacy

Last, the plaintiffs assert that Regulation 61-12 violates their right to privacy. Specifically, the plaintiffs assert that patients' names and medical records are subject to government review. "The constitutional right to privacy extends to two types of interests; 'one is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain kinds of important decisions.'" Walls v. City of Petersburg , 895 F.2d 188, 192 (4th Cir. 1990) (quoting Whalen v. Roe, 429 U.S. 589, 599-600 (1977)). "Personal, private information in which an individual has a reasonable expectation of confidentiality is protected by one's constitutional right to privacy." Id. "The right to privacy, however, is not absolute." Id. "If the information is protected by a person's right to privacy, then the defendant has the burden to prove that a compelling governmental interest in disclosure outweighs the individual's privacy interest." Id.

The defendants do not dispute that an individual has a reasonable expectation of confidentiality in the medical records at issue, and it appears that the plaintiffs object only to the availability of records which contain identifying information. (Pl.'s Mem. Of Law on Remaining Claims at 9.) While the Fourth Circuit has recognized that the "inspections ensure compliance with healthcare standards," Bryant, 222 F.3d at 171, the defendants have provided the court with no compelling interest in the disclosure of identifying information. The defendants argue that there are multiple safeguards in place to protect the confidentiality of the information contained in the medical records. This is irrelevant, however, if the defendants cannot articulate a compelling interest in viewing the information. Therefore, the court finds that sec-

tion 102(F)(2) of Regulation 61-12, which requires that "department inspectors shall have access to all properties and areas, objects, records, and reports, and shall have the authority to make photocopies of those documents required in the course of inspection or investigations," to be unconstitutional insofar as it requires access to identifying information.[2] See Thornburgh v. American College of Obstetrics and Gynecology, 476 U.S. 747, 766 (1985) ("The decision to terminate a pregnancy is an intensely private one that must be protected in a way that assures anonymity").

E. Severability

Because the court determines that a portion of Regulation 61-12 is unconstitutional, it must consider whether that portion of Regulation 61-12 is severable from the remaining regulation. "A statute may be constitutional and valid in part and unconstitutional and invalid in part." Thayer v. South Carolina Tax Comm'n, 413 S.E.2d 810, 814 (1992). "The test for severability is whether the constitutional portion of the statute remains complete in itself, wholly independent of that which is rejected, and is of such a character as that it may fairly be presumed that the Legislature would have passed it independent of that which is in conflict with the Constitution." Id. at 814-15 (internal quotations and citations omitted). Even in the absence of a severability clause, it is clear that declaring the portion of the regulation which allows the defendants to inspect records which include identifying information is easily severable, leaving the remaining regulation complete.

Therefore, the court finds that the unconstitutional portion of Regulation 61-12 is severable.

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[2] This constitutional problem can be cured by the plaintiffs redacting the documents to remove such information.

III. ORDER

In light of the above findings of fact and conclusions of law, it is

ORDERED that plaintiffs' constitutional challenge to Regulation 61-12 fails except for the provision which allows for the inspection of documents which contain identifying information. The statute is only unconstitutional to the degree that the documents are not redacted to remove such information. It is further

ORDERED that the preliminary injunction now in place is hereby dissolved.

IT IS SO ORDERED.

/s/
Henry M. Herlong, Jr.
United States District Judge

Greenville, South Carolina
August 31, 2001

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

FILED
November 8, 2002

No. 01-2090
CA-96-1898-6-20

GREENVILLE WOMEN'S CLINIC; WILLIAM LYNN, MD, on behalf of themselves and their patients seeking abortions

Plaintiffs – Appellants

and

CHARLESTON WOMEN'S MEDICAL CLINIC, INCORPORATED

Plaintiff

v.

COMMISSIONER, SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL; GOVERNOR OF SOUTH CAROLINA; CHARLES MOLONY CONDON, in his official capacity as Attorney General of the State of South Carolina

Defendants – Appellees

No. 01-2235
CA-96-1898-6-20

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and

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v.

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Defendants – Appellants

On Petition for Rehearing and Rehearing En Banc

Appellants' petition for rehearing and rehearing en banc was submitted to the Court. A majority of judges having voted in a requested poll of the Court to grant rehearing en banc,

IT IS ORDERED that rehearing en banc is granted.

IT IS FURTHER ORDERED that this case shall be calendared for argument at the January 21 - 24, 2003 session of Court. Within ten days of the date of this order, twenty (20) additional copies of appellant's brief, twenty (20) additional copies of appellee's brief, twenty (20) additional copies of

the appellant's reply brief, if any, twenty (20) additional copies of amicus curiae brief, if any, and twenty (20) additional copies of any previously filed supplemental authorities pursuant to Rule 28(j), FRAP, shall be filed. Counsel for amicus parties, if any, must file a motion for leave to participate in oral argument should they wish to be heard at argument.

Appellants will file twenty (20) additional copies of the joint appendix.

For the Court,

/s/ Patricia S. Connor
CLERK

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

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November 15, 2002

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Defendants – Appellants

On Petition for Rehearing and Rehearing En Banc

This court's order dated November 8, 2002, was improvidently entered and is now vacated.

On the request for a poll on the motion for rehearing en banc, Judge Wilkins, Michael, Motz, King, and Gregory voted to rehear the case. Chief Judge Wilkinson and Judges Widener, Niemeyer, and Luttig voted against rehearing the case, and Judges Williams and Traxler were disqualified from voting. Because a majority of the active judges did not vote in favor of the motion, it is denied.

Entered at the direction of Judge Niemeyer for the Court.

For the Court,
/s/ Patricia S. Connor
CLERK

South Carolina Department of Health and Environmental Control

Regulation Number 61-12

Standards for Licensing

Abortion Clinics

[*logo*]

Promulgated by the Board of Health and Environmental Control

Administered by the Division of Health Licensing

Published in the State Register,
Volume 20, Issue 6, June 28, 1996

This is a courtesy copy of Regulation 61-12

The official document is on record in the State Register and the Code or Regulations of S.C., 1976, as amended.

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South Carolina
Department of Health and Environmental Control

REGULATION 61-12.
STANDARDS FOR LICENSING ABORTION CLINICS

Statutory Authority: Sections 44-41-10, et seq., and 44-7-110, et seq., of the Code of Laws of South Carolina, 1976, as amended.

CHAPTER 1 - DEFINITIONS AND REQUIREMENTS FOR LICENSURE

SECTION 101. Definitions

For the purposes of these regulations, the following definitions apply:

A. Abortion. The use of an instrument, medicine, drug, or other substance or device with intent to terminate the pregnancy of a woman, known to be pregnant, for reasons other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

B. Abortion Clinic. Any facility, other than a hospital as defined in Section 101.J, in which any second trimester or five or more first trimester abortions per month are performed.

C. Allied Health Professional. A person other than a physician who possesses specialized training and skill acquired by completing certain courses of study or intensive job-related training and, where applicable, has been duly licensed or registered by appropriate licensing or certification agencies. All allied health professionals must be supervised by a physician.

D. Conception. The fecundation of the ovum by the spermatozoa.

E. Consent. A signed and witnessed voluntary agreement to the performance of an abortion.

F. Department. The South Carolina Department of Health and Environmental Control.

G. Emancipated Minor. A minor who is or has been married or has by court order been freed from the care, custody, and control of her parents.

H. Fetal Death. Death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

I. Fire Safety Authority. The State Fire Marshal, or his designee, who performs facility fire and safety inspections.

J. Hospital. An institution licensed for hospital operation by the Department in accordance with the provisions of Article 3, Chapter 7, Title 44, of the S.C. Code of Laws, 1976, as amended, and that has also been certified by the Department to be a suitable facility for the performance of abortion.

K. In Loco Parentis. Any person over the age of 18 who has placed him/herself in the position of a lawful par-

ent by assuming obligations that are incidental to the parental relationship and has so served for a period of 60 days.

L. Licensee. The person, partnership, corporation, association, organization, or professional entity on whom rests the ultimate responsibility and authority for the conduct of the abortion clinic.

M. Medical Emergency. That condition which, on the basis of the physician's good faith judgment, so complicates a pregnancy as to necessitate an immediate abortion to avert the risk of her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily functions.

N. Minor. A female under the age of 17.

O. Physician. A person licensed to practice medicine in this State.

P. Pregnancy. The condition of a woman carrying a fetus or embryo within her body.

Q. Probable Gestational Age of the Embryo or Fetus. What, in the judgment of the attending physician, based upon the attending physician's examination and the woman's medical history, is with reasonable probability, the gestational age of the embryo or fetus at the time the abortion is planned to be performed. This estimate must be guided by recommendations found in The American College of Obstetricians and Gynecologists Standards for Obstetric-Gynecologic Services, i.e., calculated from the first day of the last menstrual period.

R. Products of Conception. Fetal and embryonic tissues resulting from implantation in the uterus.

S. Trimester. A 12-week period of pregnancy.

1. First. The first 12 weeks of pregnancy commencing with conception rather than computed on the basis of the menstrual cycle.

2. Second. That portion of a pregnancy following the 12th week and extending through the 24th week of gestation.

3. Third. That portion of pregnancy beginning with the 25th week of gestation.

4. All other references in this regulation to gestational age will refer to that calculated from the first day of the last menstrual period as used in The American College of Obstetricians and Gynecologists Standards for Obstetric-Gynecologic Services. The following is furnished to provide clarification of gestational age:

Calculation	Weeks of Gestational Age								
Conception	8	10	12	14	16	18	20	22	24
LMP	10	12	14	16	18	20	22	24	26

T. Viability. That stage of human development when the fetus is potentially able to live outside of the mother's womb with or without the aid of artificial life support systems. (Section 44-41-10(l) of the SC Code of Laws further states that "for the purposes of this chapter, a legal presumption is hereby created that viability occurs no sooner than the twenty-fourth week of pregnancy." The "twenty-fourth week," as

stated in the S.C Code, is based on computation from date of conception, i.e., the twenty-sixth week from the first day of the last menstrual period.)

SECTION 102. License Requirements

A. License. It shall be unlawful to operate an abortion clinic within South Carolina without possessing a valid license issued annually by the Department. (I)

B. Issuance of License. A license is issued pursuant to the provisions of Section 44-41-10 et seq., of the South Carolina Code of Laws of 1976, as amended, and these standards, and shall be posted in a conspicuous place in a public area within the facility. The issuance of a license does not guarantee adequacy of individual care, treatment, personal safety, fire safety or the well-being of any occupant of a facility. A license is not assignable or transferable and is subject to revocation by the Department for failure to comply with the laws and regulations of the State of South Carolina.

C. Effective Date and Term of License. A license shall be effective for a 12-month period following the date of issue and shall expire one year following such date; however, a facility that has not been inspected during that year may continue to operate under its existing license until an inspection has occurred.

D. Separate Licenses. Separate licenses are required for facilities not maintained on the same premises.

E. Licensing Fees. The initial and annual license fee shall be $500.00 for each licensed facility. Such fee

shall be made payable to the Department. Fees are non-refundable.

F. Inspections. Each facility shall be inspected prior to initial licensure and at least annually thereafter by authorized representatives of the Department.

1. All licensed facilities are subject to inspection at any time.

2. Department inspectors shall have access to all properties and areas, objects, records and reports, and shall have the authority to make photocopies of those documents required in the course of inspections or investigations. (II)

G. Initial License. A new facility, or one that has not been continuously licensed under these or prior standards, shall not provide care to patients until it has been issued an initial license. When it is determined that the facility is in compliance with the requirements of these standards, and a properly completed application and licensing fee have been received by the Department, a license shall be issued. Chapter 9 of this regulation sets forth the prerequisites for initial licensure. (I)

H. License Renewal. Applicants for an annual license renewal shall file an application with the Department, pay a license fee, and undergo a licensing inspection.

I. Noncompliance. When noncompliance(s) with the licensing standards exists, the applicant or licensee shall be notified by the Department of the violation(s) and required to provide information as to how and

when each violation will be corrected and how future occurrences may be prevented.

J. Facility Name. No proposed abortion clinic shall be named, nor may any existing abortion clinic have its name changed to, the same or similar name as any other abortion clinic licensed in the State. If it is part of a "chain operation" it shall then have the geographic area in which it is located as part of its name.

K. Change of License. A facility shall request issuance of an amended license by application to the Department prior to any of the following circumstances:

1. Change of ownership by purchase or lease;

2. Change of facility's name or address.

L. Exceptions to Licensing Standards. The Department may make exception(s) to these standards where it is determined that the health and welfare of the community require the services of the facility and that the exception(s), as granted, will have no significant adverse impact on the health, safety, or welfare of the facility's patients.

SECTION 103. Penalties

When it determines that a facility is in violation of any statutory provision, rule or regulation relating to the operation or maintenance of such facility, the Department, upon proper notice, may deny, suspend, or revoke licenses, or assess a monetary penalty. Under such conditions, the following shall apply:

A. Class I violations are those that the Department determines to present an imminent danger to the health, safety, or welfare of the patients of the facility or a substantial probability that death or serious physical harm could result therefrom. A physical condition or one or more practices, means, methods or operations in use in a facility may constitute such a violation. The condition or practice constituting a Class I violation shall be abated or eliminated immediately unless a fixed period of time, as stipulated by the Department, is required for correction. Each day such violation shall exist after expiration of said time shall be considered a subsequent violation.

B. Class II violations are those, other than Class I violations, that the Department determines to have a direct or immediate relationship to the health, safety or well-being of the facility's patients. The citation of a Class II violation shall specify the time within which the violation is required to be corrected. Each day such violation shall exist after expiration of said time shall be considered a subsequent violation.

C. Class III violations are those that are not classified as Class I or II in these regulations or those that are against the best practices as interpreted by the Department. The citation of a Class III violation shall specify the time within which the violation is required to be corrected. Each day such violation shall exist after expiration of said time shall be considered a subsequent violation.

D. Class I and II violations are indicated by notation after each applicable section, i.e., (I) or (II). Violations of sections that are not annotated in that manner denote Class III violations.

E. In arriving at a decision to penalize a facility, the Department will consider the following factors: specific conditions and their impact or potential impact on health, safety or well-being; efforts by the facility to correct; overall conditions; history of compliance; any other pertinent conditions that may be applicable to current statutes and regulations.

F. When a decision is made to assess monetary penalties, the following schedule will be used as a guide to determine the dollar amount:

Frequency of violation of standard within a 24-month period: MONETARY PENALTY RANGES

Frequency	Class I	Class II	Class III
1st	$ 200 – 1000	$ 100 – 500	$ 0
2nd	500 – 2000	200 – 1000	100 – 500
3rd	1000 – 5000	500 – 2000	200 – 1000
4th	5000	1000 – 5000	500 – 2000
5th	5000	5000	1000 – 5000
6th	5000	5000	5000

G. Any facility that is dissatisfied with Department decisions may request a hearing pursuant to the Administrative Procedures Act.

CHAPTER 2 - ADMINISTRATION AND MANAGEMENT

SECTION 201. Licensee (II)

A. The licensee of each facility has the ultimate responsibility for the overall operation of the facility. Every facility shall be organized, equipped, staffed and administered to provide adequate care for each person admitted.

B. Policies and procedures for operation of the facility shall be formulated and reviewed annually by the licensee of the facility. They shall include but not be limited to:

1. Purpose of the facility, to include scope and quality of services;

2. Ensuring compliance with all relevant federal, state, and local laws that govern operations of the facility;

3. Personnel policies and procedures, to include in-service training requirements;

4. The person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible;

5. Provision for annual review and evaluation of the facility's policies, procedures, management and operation;

6. Provision for a facility-wide quality improvement program to evaluate patient care. The program shall be ongoing, have statistical summaries, and have a written plan of implementation.

7. Patient rights and grievance procedures;

8. Functional safety and maintenance policies and procedures;

9. Incident reporting;

10. Consent must be informed, shall be obtained prior to the procedure, and shall include evidence of an explanation by a physician or allied health professional of the services offered and potential risks. Documentation of the informed consent must be filed in the patient's record.

SECTION 202. Administrator (II)

An administrator shall be selected by the licensee and shall have the ability and authority to manage and administer the facility. Any change in the position of the administrator shall be reported immediately by the licensee to the Department in writing. An individual shall be appointed in writing to act in the absence of the administrator.

SECTION 203. Administrative Records

The following administrative documents and references shall be on file in the facility:

A. Current policies and procedures concerning the operation of the facility; (II)

B. Current memorandums of agreement and credentialing documentation.

C. A current copy of these regulations;

D. Annual elevator safety inspections, if applicable;

E. Annual heating, ventilation, and air conditioning inspection report.

SECTION 204. Personnel (II)

Each facility shall have a staff that is adequately trained and capable of providing appropriate service and supervision to the patients.

A. The licensee shall obtain written applications for employment from all employees. The licensee shall obtain and verify information on the application as to education, training, experience, appropriate licensure, if applicable, and health and personal background of each employee.

B. Prior to performing job duties, all employees, to include volunteers who have direct patient contact within the clinic, shall have tuberculin skin testing conducted unless a previously positive reaction is documented in millimeters. The intradermal (Mantoux) method, using five tuberculin units of stabilized purified protein derivative (PPD) is to be used. For employees/volunteers who have no documentation of a negative PPD result during the preceding 12 months, then the two-step procedure (one PPD test with negative result followed one to three weeks later by another PPD test) is required to establish a reliable baseline. If employees/volunteers have complete

documentation of a negative PPD during the preceding 12 months (may be a single PPD or a two-step PPD), then a single PPD is acceptable to establish the baseline for current employment.

1. Persons with negative tuberculin skin tests who have direct contact with patients shall have an annual tuberculin skin test.

2. There is no need to perform an initial or routine chest X-ray on employees or volunteers with negative tuberculin tests who are asymptomatic.

3. Personnel with a positive reaction to the skin test shall have no patient contact until certified non-contagious by a physician.

4. Employees and volunteers with reactions of 10mm and over to the pre-employment tuberculin test, those new employees/volunteers who have previously-documented positive reactions, those with newly-converted skin tests and those with symptoms suggestive of TB (e.g., cough, weight loss, night sweats, fever, etc.), shall be given a chest X-ray to determine whether TB disease is present. If TB disease is diagnosed, appropriate treatment shall be given and contacts examined.

5. Personnel who are known or suspected to have TB shall be required to be evaluated by a physician and will not be allowed to return to work until they have been certified non-contagious by the physician.

6. Preventive treatment of personnel with new positive reactions is essential, and shall be considered

for all infected employees/volunteers who have patient contact, unless specifically contraindicated. Routine annual chest X-rays of persons with positive reactions do not prevent TB and therefore are not a substitute for preventive treatment nor are required.

a. Employees and volunteers who complete treatment, either for disease or infection, may be exempt from further routine chest radiographic screening unless they have symptoms of TB.

b. Positive reactors who are unable or unwilling to take preventive treatment need not receive an annual chest X-ray. These individuals must be informed of their lifelong risk of developing and transmitting TB to individuals in the institution and in the community. They shall be informed of symptoms which suggest the onset of TB, and the procedure to follow should such symptoms develop.

7. Post-exposure skin tests should be provided for tuberculin negative employees/volunteers within 12 weeks after termination of contact for any suspected exposure to a documented case of pulmonary TB.

8. A person shall be designated in writing at each facility to coordinate TB screening of personnel and any other TB control activities.

C. All professional and allied health professional staff members shall be currently certified with American Red Cross or American Heart Association CPR and

capable of recognizing symptoms of distress. A professional or allied health professional staff member who is legally qualified to perform advanced cardiac life support must be present while patients are undergoing abortion procedures/ recovery in the facility. (I)

D. No employee or volunteer of the facility, while afflicted with any infected wounds, boils, sores, or an acute respiratory infection, or any other contagious disease or illness, shall work in any capacity in which there is a likelihood of such person transmitting disease to other individuals.

E. Each facility shall have and execute a written orientation program to familiarize each new staff member with the facility and its policies and procedures, to include, as a minimum, fire safety and other safety measures, medical emergencies, and infection control.

F. Inservice training programs shall be planned and provided for all employees and volunteers to insure and maintain their understanding of their duties and responsibilities. Records shall be maintained to reflect program content and individual attendance. The following training shall be provided at least annually:

1. Infection control, to include as a minimum, universal precautions against blood-borne diseases, general sanitation, personal hygiene such as handwashing, use of masks and gloves, and instruction to staff if there is a likelihood of transmitting a disease to patients or other staff members;

2. Fire protection, to include evacuating patients, proper use of fire extinguishers, and procedures for reporting fires:

3. Confidentiality of patient information and records, and protecting patient rights;

4. Licensing regulations.

G. Job Descriptions.

1. Written job descriptions that adequately describe the duties of every position shall be maintained.

2. Each job description shall include: position title, authority, specific responsibilities and minimum qualifications.

3. Job descriptions shall be reviewed at least annually, kept current and given to each employee and volunteer when assigned to the position and when revised.

H. A personnel file shall be maintained for each employee and for each volunteer. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information. The file shall contain a current job description that reflects the individual's responsibilities and work assignments, and documentation of the person's orientation, in-service education, appropriate licensure, if applicable, and TB skin testing.

SECTION 205. Clinical Staff (II)

A. Physicians, nurses, and allied health professionals shall constitute the clinical staff.

B. The clinical staff shall meet at least quarterly to review and analyze their clinical experiences; minutes shall be maintained of such meetings.

C. Physicians. (I)

1. Abortions shall be performed only by physicians who are licensed to practice medicine in this State and who are properly qualified by training and experience to perform pregnancy termination procedures.

2. The facility shall enter into a signed written agreement with at least one physician board-certified in obstetrics and gynecology (if not one on staff) who has admitting privileges at one or more local hospitals with OB/GYN services to ensure his/her availability to the staff and patients during all operating hours.

3. A physician must remain on the premises until all patients are stable, and are ready for discharge. A physician must sign the discharge order and be readily accessible and available until the last patient has been discharged.

D. Nursing.

1. Nursing care shall be under the supervision of a registered nurse currently licensed in this State.

2. A registered nurse shall be on duty to provide or supervise all nursing care of patients in preparation, during the termination procedure, the recovery period and until discharge by the attending physician.

3. Licensed practical nurses, working under appropriate supervision and direction of a registered nurse, may be employed as components of the nursing staff.

E. Allied health professionals, working under appropriate direction and supervision, may be employed to work only within areas where their competency has been established.

F. If ultrasonography is conducted in the clinic, the procedure shall be conducted by a physician or by an ultrasound technician who shall have documented evidence of completion of a training course in ultrasonography.

SECTION 206. Consent of the Patient (I)

A physician shall not perform an abortion without first obtaining a signed and dated consent of the pregnant woman pursuant to the provisions of Section 44-41-30 of the SC Code of Laws, 1976, as amended.

SECTION 207. Abortion Performed Upon Minors (I)

No person may perform an abortion upon a minor unless consent is obtained pursuant to the provisions of Section 44-41-31 of the SC Code of Laws, 1976, as amended.

SECTION 208. Dissemination of Information (I)

Clinics must comply with the Woman's Right to Know Act, Section 44-41-310 et seq., of the SC Code of Laws, 1976, as amended, and maintain an adequate supply of current printed material from the Department which has not been altered in content.

SECTION 209. Patients' Rights (II)

A. The facility shall have written policies and procedures to assure the individual patient the right to dignity, privacy, safety, and to register complaints with the Department. These patients' rights shall be approved by the licensee.

B. Each facility shall display in a conspicuous place a copy of the patients' rights. In addition, a copy signed by the patient shall be included in the medical record.

CHAPTER 3 - PATIENT CARE

SECTION 301. Policies and Procedures (II)

Abortion clinics shall not serve patients whose needs exceed the resources and/or capabilities of the clinic. The facility shall formulate and adhere to written patient care policies and procedures designed to ensure professional and safe care for patients, to include but not limited to:

A. Admission criteria;

B. Physician and nurse responsibilities for the services offered;

C. Specific details regarding the pre-operative procedures performed, to include:

1. History and physical examination, to include verification of pregnancy, estimation of gestational age, identification of any preexisting conditions or complications;

2. Special examinations, lab procedures, and/or consultations required, to include ultrasonography required when gestational age is clinically estimated to be equal to or more than 14 weeks from the first day of the last menstrual period as established by the physician's performance of a bimanual physical examination. Policies and procedures should also indicate that ultrasound is recommended when gestational age is equal to or more than 12 weeks from the first day of the last menstrual period as established by the performance of a bimanual physical examination or if the physical examination and clinical evidence is inconclusive as to the gestational age.

D. The actual abortion procedure, to include the use of:

1. IV's;

2. Fluids;

3. Analgesia/anesthesia. General anesthesia shall be administered only by a certified registered nurse anesthetist, anesthesiologist, or dentist anesthetist or physician anesthetist.

4. Tissue examination/disposal.

E. Post-procedure care/recovery room procedures to include emergency care;

F. Provisions for the education of patient, family and others, as appropriate in pre and post-procedure care;

G. Plans for follow-up of patient after discharge from the facility, to include arrangements for post-operative visit, and specific instructions in case of emergency;

H. Management and appropriate referral of high-risk conditions;

I. Transfer of patients who, during the course of pregnancy termination are determined to need care beyond that of the facility;

J. Infection control and sanitation procedures to include duties and responsibilities of the infection control committee that shall include the development and implementation of specific patient care and administrative policies aimed at investigating, controlling and preventing infections in the facility;

K. Registration of fetal death or death certificates, when applicable.

SECTION 302. Limitation of Services Offered by Abortion Clinics (I)

A. Abortions performed in abortion clinics shall be performed only on patients who are within 18 weeks from the first day of their last menstrual period. Those beyond 18 weeks shall be performed in a hospital. A licensed ambulatory surgical facility that is also licensed as an abortion clinic may perform abor-

tions on patients who are up to 26 weeks after the first day of their last menstrual period.

B. Clinics performing abortions beyond 14 weeks from the first day of the last menstrual period must meet the requirements of Section 309.

SECTION 303. Pharmaceutical Services (II)

Pharmaceutical services shall be provided in accordance with accepted professional practice and federal, state and local statutes and regulations.

A. Emergency Drugs:

1. Emergency Kit or Emergency Drugs. Each facility shall maintain an emergency kit or stock supply of drugs and medicines for the use of the physician in treating the emergency needs of patients. This kit or medicine shall be stored in such a manner as to prohibit its access by unauthorized personnel. A listing of contents by drawer or shelf shall be placed on the cabinet or emergency cart to allow quick retrieval. Contents shall correspond with the inventory list. Drugs and equipment must be available within the facility to treat, as a minimum, the following conditions: (I)

a. Cardiac arrest;

b. Seizure;

c. Asthmatic attack;

d. Allergic reaction;

e. Narcotic toxicity;

f. Hypovolemic shock;

g. Vasovagal shock.

2. Drug Reference Sources. Each facility shall maintain reference sources for identifying and describing drugs and medicines.

B. Administering Drugs and Medicines. Drugs and medicines shall not be administered to individual patients or to anyone within or outside the facility except by those authorized by law under orders of a physician duly licensed to prescribe drugs. Such orders shall be in writing and signed personally by the physician who prescribes the drug or medicine.

C. Medicine Storage. Medicines and drugs maintained in the facility for daily administration shall not be expired and shall be properly stored and safeguarded in enclosures of sufficient size that are not accessible to unauthorized persons. Refrigerators used for storage of medications shall maintain an appropriate temperature as determined by the requirements established on the label of medications. A thermometer accurate to ±3 degrees Fahrenheit shall be maintained in these refrigerators. Only authorized personnel shall have access to storage enclosures. Controlled substances and ethyl alcohol, if stocked, shall be stored under double locks and in accordance with applicable state and federal laws.

D. Medicine Preparation Area. Medicines and drugs shall be prepared for administration in an area that contains a counter and a sink. This area shall be lo-

cated in such a manner as to prevent contamination of medicines being prepared for administration.

E. Controlled Substances Registration.

1. If a stock of controlled drugs is to be maintained at the facility, a physician on the clinic staff shall obtain an individual practitioner South Carolina Controlled Substances Registration and a Drug Enforcement Administration (DEA) Registration as registrant for the facility. This physician shall be responsible for the proper safeguarding and handling of controlled substances within the facility, and shall be certain that all possible control measures are observed and that any suspected diversion or mishandling of controlled substances is reported immediately to the Bureau of Drug Control of the Department.

2. With a written power of attorney, this physician may grant permission to any other physician who possesses an individual practitioner South Carolina Controlled Substances Registration and a DEA Registration to administer, order for administration, or dispense any controlled substances maintained by the facility.

F. Records. Records shall be kept of all stock supplies of controlled substances giving an accounting of all items received and/or administered.

G. Poisonous Substances. All poisonous substances must be plainly labeled and kept in a cabinet or closet separate from medicines and drugs to be prepared for administration. (I)

SECTION 304. Laboratory Services (II)

A. Laboratory services shall be provided on site or through arrangement with a laboratory certified to provide the required procedures under the Clinical Laboratory Improvement Amendments of 1988 (CLIA-88).

1. Facilities for collecting specimens shall be available on site.

2. If laboratory services are provided on site they shall be directed by a person who qualifies as a director under CLIA-88 and shall be performed in compliance with CLIA-88 standards.

B. Prior to the procedure, laboratory tests shall include a recognized urine pregnancy test unless the physician identifies fetal heart beats or fetal movements on physical examination. If positive, the following additional tests are required:

1. Urinalysis including albumin and glucose examination;

2. Hematocrit or hemoglobin;

3. Determination of Rh factor (including the Du variant when the patient is Rh negative); Rh (D) immune globulin (human) shall be administered, prior to discharge, to patients who are determined to be Rh negative.

C. Other laboratory tests to be administered:

1. Testing for Chlamydia and gonorrhea;

2. Syphilis serology shall be offered;

3. A Papanicolaou procedure shall be offered;

4. Referral for chest X-ray, if indicated;

5. Other tests as deemed appropriate by the physician.

D. Aspirated tissues shall be examined to verify that villi or fetal parts are present; if villi or fetal parts cannot be identified with certainty, the tissue specimen shall be sent for further pathologic examination and the patient alerted to the possibility of an ectopic pregnancy.

E. A written report of each laboratory test and examination shall be a part of the patient's record.

F. If a patient is bleeding profusely and a transfusion of red blood cells is necessary, she should be administered fluids and transported immediately to a hospital that routinely performs crossmatches and transfuses patients.

G. All laboratory supplies shall be monitored for expiration dates, if applicable.

H. Products of conception resulting from the abortion procedure must be managed in accordance with requirements for pathological waste pursuant to Department Regulation 61-105, Infectious Waste Management Regulations. All contaminated dressings and/or similar waste shall be properly disposed of in accordance with Regulation 61-105.

SECTION 305. Emergency Care (I)

A. All staff and/or consulting physicians shall have admitting privileges at one or more local hospitals that have appropriate obstetrical/gynecological services or shall have in place documented arrangements approved by the Department for the transfer of emergency cases when hospitalization becomes necessary.

B. Equipment and services shall be provided to render emergency resuscitative and life-support procedures pending transfer of the patient to a hospital.

C. The facility shall inform, in writing, the local ambulance service which provides emergency care and transport of patients, of the location of the facility, and the nature of medical problems which may result from abortions.

SECTION 306. Equipment and Supplies (II)

There shall be appropriate equipment and supplies maintained for the patients to include but not limited to:

A. A bed or recliner suitable for recovery;

B. Oxygen with flow meters and masks or equivalent; (I)

C. Mechanical suction; (I)

D. Resuscitation equipment to include, as a minimum, resuscitation bags and oral airways; (I)

E. Emergency medications, intravenous fluids, and related supplies and equipment; (I)

F. A clock with a sweep second hand;

G. Sterile suturing equipment and supplies;

H. Adjustable examination light;

I. Containers for soiled linen and waste materials with covers;

J. Refrigerator;

K. Appropriate equipment for the administering of general anesthesia, if applicable.

SECTION 307. Consultation (II)

Arrangements shall be made for consultation or referral services in the specialties of obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, clergy, and social services, as well as any other indicated field, to be available as needed.

SECTION 308. Quality Improvement (II)

A. The facility shall establish and implement a written plan for a quality improvement program for patient care. The plan shall specify the individual responsible for coordinating the quality improvement program and shall provide for ongoing monitoring of staff and patient care services.

B. There shall be an ongoing process for monitoring and evaluating patient care services, staffing, infection prevention and control, housekeeping, sanitation, safety, maintenance of physical plant and equipment,

patient care statistics, and discharge planning services.

C. Evaluation of patient care throughout the facility shall be criteria-based, so that certain actions are taken or triggered when specific quantified, predetermined levels of outcomes or potential problems are identified.

D. The quality improvement process shall incorporate quarterly review of a minimum of five per cent of medical records of patients undergoing procedures during a given quarter, but not less than five records shall be reviewed.

E. The quality improvement process shall include evaluation by patients of care and services provided by the facility. If the families of patients are involved in the care and services provided by the facility, the quality improvement process shall include a means for obtaining input from families of patients.

F. The administrator shall review the findings of the quality improvement program to ensure that effective corrective actions have been taken, including as a minimum, policy revisions, procedural changes, educational activities, and follow-up on recommendations, or that additional actions are no longer indicated or needed.

G. The quality improvement program shall identify and establish indicators of quality care, specific to the facility, that shall be monitored and evaluated.

H. The results of the quality improvement program shall be submitted to the licensee for review at least annu-

ally and shall include at least the deficiencies found and recommendations for corrections or improvements. Deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee.

SECTION 309. Requirements for Clinics Performing Abortions Beyond 14 Weeks (I)

Clinics which perform abortions beyond 14 weeks from the first day of the last menstrual cycle shall, in addition to those requirements in all other sections of this regulation, have the following in place:

A. Physicians shall be board-certified or a candidate for board-certification in obstetrics and gynecology, general surgery, or family practice;

B. Physicians shall have admitting privileges at one or more local hospitals that have appropriate obstetrical/gynecological services;

C. Laryngoscopes, endotracheal tubes, and defibrillator;

D. Laboratory tests/procedures shall include:

1. White blood count and determination of blood type;

2. Sickle cell, when indicated;

3. Ultrasonogram.

CHAPTER 4 - MEDICAL RECORDS AND REPORTS

SECTION 401. Medical Records (II)

Medical records shall be maintained for all patients examined or treated in the clinic. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information. All information shall be centralized in the patient's medical record. All entries shall be legibly written or typed, dated and signed.

A. The record shall include as a minimum the following information:

1. A face sheet with patient identification data, to include but not be limited to: name, address, telephone number, social security number, date of birth, father's and mother's names when patient is a minor, husband's name, and name, address and telephone number of person to be notified in the event of an emergency;

2. Signed consent for the procedure;

3. Date of initial examination;

4. Date of abortion;

5. Referring and attending physicians' names and phone numbers, if applicable;

6. Complete medical history to include medications currently being taken;

7. Physical examination, to the extent necessary to determine the health status of the patient, within 15 days of the procedure, including detail of findings of pelvic examination and estimated gestational age, according to the first day of the last menstrual period;

8. Results of diagnostic tests and/or examinations, e.g., X-ray, electrocardiography, clinical laboratory, pathology, consultations, ultrasound;

9. Pre-operative diagnosis;

10. Counselor's notes;

11. Physician's orders;

12. Complete record of abortion procedure to include:

    a. Vital signs, i.e., temperature, pulse, respiration, and blood pressure, prior to and following the procedure;

    b. Name of procedure performed;

    c. Anesthetic agent utilized;

    d. Name of attending physician performing the procedure;

    e. Names of clinical assistants in attendance, to include other physicians, physician's assistants, anesthetists, nurses, or specially-trained technicians;

f. Signature of physician performing the procedure.

13. Nurses' notes;

14. Progress notes to include a post-anesthesia note if general anesthesia is utilized;

15. Attending physician's description of gross appearance of tissue removed;

16. Final diagnosis;

17. Condition on discharge;

18. Post-op orders and follow-up care;

19. Documented verification that the woman has been presented printed materials as required in the Woman's Right-to-Know Act;

20. In the case of an unemancipated minor or mentally incompetent person, a copy of the court order or written consent authorizing the abortion.

B. The attending physician must complete and sign the medical record within 72 hours following discharge.

SECTION 402. Records Storage

All records shall be treated as confidential and shall be stored in a safe location for a minimum of 10 years. When records are stored in a location other than the clinic, and upon closure of the clinic, for any reason, the medical records shall be stored in a safe location for that minimum period, with the Department informed of that location. The medium in which

the records are stored, e.g., optical disk, microfiche, is a facility decision.

SECTION 403. Reports (II)

A. The following shall be reported to Vital Records and Public Health Statistics of this Department:

1. Any abortion performed, to be reported by the performing physician on the standard form for reporting abortions, within seven days after the abortion is performed;

2. A fetal death when the fetus has completed or passed the age or weight requiring a report, pursuant to the standards in Regulation 61-19, Vital Statistics.

B. A record of each accident or incident occurring in the facility which involves patients, staff, or visitors, including medication errors and adverse drug reactions, shall be prepared immediately. Accidents or incidents resulting in serious injury shall be reported, in writing, to the Department within 10 days of the occurrence; if a death occurs, other than a fetal death, it shall be reported to the Department not later than the next Department work day (Monday through Friday). Accidents and incidents that must be reported include, but are not limited to:

1. Those leading to hospitalization;

2. Those leading to death, other than a fetal death;

3. Adverse drug reactions.

CHAPTER 5 - FUNCTIONAL SAFETY AND MAINTENANCE (II)

SECTION 501. Policies and Procedures

A. Written policies and procedures shall be developed to enhance safety within the facility and on its grounds and to minimize hazards to patients, staff and visitors.

B. The policies and procedures shall include, but not be limited to:

1. Safety rules and practices pertaining to personnel, equipment, gases, liquids, drugs, supplies and services;

2. Provisions for reporting and investigating accidental events regarding patients, visitors and personnel and corrective action taken;

3. Provisions for disseminating safety-related information to employees and users of the facility;

4. Provision for syringe and needle handling and storage.

5. Provisions for managing infectious waste from generation to disposal according to Regulation 61-105.

SECTION 502. Disaster Preparedness

A. The facility shall have posted, in conspicuous places throughout the facility, a plan for evacuation of patients, staff, and visitors in case of fire or other emergency. (I)

B. A facility that participates in a community disaster plan shall establish plans, based on its capabilities, to meet its responsibilities for providing emergency care.

SECTION 503. Maintenance

A. Facility Maintenance. A facility's structure, its component parts, and all equipment such as elevators, furnaces and emergency lights, shall be kept in good repair and operating condition. Areas used by patients shall be maintained in good repair and kept free of hazards. All wooden surfaces shall be sealed with non-lead-based paint, lacquer, varnish, or shellac that will allow sanitization.

B. Equipment Maintenance. When patient monitoring equipment is utilized, a written preventive maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, not less than annually, to insure proper operation and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before returning it to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance.

CHAPTER 6 - INFECTION CONTROL AND SANITATION (II)

SECTION 601. General

Policies and procedures shall be established in writing to assure safe and aseptic treatment and protection of all patients and personnel against cross-infection.

SECTION 602. Sterilization Procedures

A. Adequate space shall be provided for storage, maintenance and distribution of sterile supplies and equipment.

B. Sterile supplies and equipment shall not be mixed with unsterile supplies, and shall be stored in dust-proof and moisture-free units. They shall be properly labeled.

C. Sterilizing equipment of appropriate type shall be available and of adequate capacity to properly sterilize instruments and materials. The sterilizing equipment shall have approved control and safety features.

1. There must be documentation of each load run daily. A biological test of the autoclave shall be run daily and the results maintained on a log.

2. Each separate package of instruments to be sterilized must have internal and external chemical indicators.

3. The accuracy of instrumentation and equipment shall be provided by periodic calibration and/or

preventive maintenance as necessary, but not less than annually, and a log maintained.

D. The policies and procedures shall indicate how the shelf life of a packaged sterile item is determined. Methods approved for use are:

1. Date of expiration being marked on the item; or

2. Event-related, i.e., day-to-day expiration, utilizing such wording as, "sterile unless the integrity of the package is compromised."

SECTION 603. Linen and Laundry

A. An adequate supply of clean linen or disposable materials shall be maintained in order to insure change of linen on procedure tables between patients.

B. Provisions for proper laundering of linen and washable goods shall be made. Soiled and clean linen shall be handled and stored separately. Storage shall be in covered containers.

C. A sufficient supply of cloth or disposable towels shall be available so that a fresh towel can be used after each handwashing. Towels shall not be shared.

SECTION 604. Housekeeping

A. General. A facility shall be kept neat, clean and free from odors. Accumulated waste material must be removed daily or more often if necessary. There must be frequent cleaning of floors, walls, ceilings, woodwork, and windows. The premises must be kept free from rodent and insect infestation. Bath and toilet fa-

cilities must be maintained in a clean and sanitary condition at all times.

B. Cleaning materials and supplies shall be stored in a safe manner. All harmful agents shall be locked in a closet or cabinet used for this purpose only.

C. Dry sweeping and dusting of walls and floors are prohibited.

SECTION 605. Refuse and Waste Disposal

A. All garbage and waste shall be collected, stored and disposed of in a manner designed to prevent the transmission of disease. Containers shall be washed and sanitized before being returned to work areas. Disposable type containers shall not be reused.

B. Containers for garbage and refuse shall be covered and stored outside and placed on an approved platform to prevent overturning by animals, the entrance of flies or the creation of a nuisance. All solid waste shall be disposed of at sufficient frequencies in a manner so as not to create a rodent, insect or other vermin problem.

C. Immediately after emptying, containers for garbage shall be cleaned.

D. All waste meeting the definition of "infectious waste" as defined in Regulation 61-105 must be managed according to the requirements of that regulation.

SECTION 606. Outside Areas

All outside areas, grounds and/or adjacent buildings shall be kept free of rubbish, grass, and weeds that may serve as a fire hazard or as a haven for insects, rodents and other pests. Outside stairs, walkways, ramps and porches shall be maintained free from accumulations of water, ice, snow and other impediments.

CHAPTER 7 - FIRE PROTECTION AND PREVENTION (I)

SECTION 701. Fire-fighting Equipment and Systems

A. All facilities located outside a fire protected area shall have a contract with the nearest fire department.

B. An evacuation plan shall be posted in prominent places and staff members shall be trained as part of their responsibilities to guide patients to the designated exits.

C. All fire protection and alarm systems and other fire fighting equipment shall be inspected and tested at least once each year, and more often if necessary to maintain them in serviceable condition.

D. Fire extinguishers of the proper type shall be installed in accordance with NFPA 10 (National Fire Protection Association) 10 requirements or as otherwise directed by fire authorities.

   1. Fire extinguishers shall be kept in condition for instant use and shall be inspected monthly by facility staff with the date of inspection recorded on a tag affixed to the extinguisher.

2. Fire extinguishers shall be inspected and/or serviced annually by personnel licensed or certified to perform fire extinguisher servicing. Servicing/inspection records shall be kept on the fire extinguishers.

E. No portable electric, open flame, or unvented heaters shall be allowed in the facility.

F. Fire Drills.

1. A fire drill shall be conducted at least once every three months. New facilities shall conduct a fire drill within the first 48 hours of operation. Each employee shall participate in a fire drill at least twice each year.

2. Records of drills shall be maintained to report the date, time, description, and evaluation of the drill, to include the names of participating staff and time for total evacuation.

G. Corridor Obstructions. All corridors and other means of egress or exit from the building shall be maintained clear and free of obstructions.

H. Corridor and Stairway Illumination. Corridors, stairs and other means of egress shall be lighted at all times with a minimum of one foot-candle at finish floor level along the path of travel.

SECTION 702. Alarms

A fire alarm system shall be provided in accordance with the provisions of NFPA 72. The fire alarm system shall be

tested monthly and each detector tested annually. Records of all tests shall be retained for at least one year.

SECTION 703. Gas Storage

Gases (flammable and nonflammable) shall be handled and stored in accordance with the provisions of applicable NFPA codes.

CHAPTER 8 - DESIGN AND CONSTRUCTION

SECTION 801. General

Every facility must be planned, designed and equipped to provide adequate facilities for the care and comfort of each patient.

SECTION 802. Local and State Codes and Standards (II)

A. Facilities shall comply with pertinent local and state laws, codes, ordinances and standards with reference to design and construction. Abortion clinics are categorized as a "business occupancy" as defined in the Standard Building Code. No facility will be licensed unless the Department has assurance that responsible local officials have approved the facility.

B. The Department uses as its basic codes: the Standard Building Code, Standard Plumbing Code, Standard Mechanical Code, and National Electrical Code. Buildings designed in accordance with the above mentioned codes will be acceptable to the Department, provided, however, that the requirements set forth in this regulation are also met.

SECTION 803. Submission of Plans and Specifications

A. New Buildings, Additions or Major Alterations to Existing Buildings. (II)

1. When construction is contemplated either for new buildings, additions or major alterations to existing buildings, the facility must contact the Division of Health Facilities Construction of this Department to discuss code and regulation requirements that apply to that project. Plans and specifications shall be submitted to the Department for review. Where the Standard Building Code or other regulations require fire-rated walls or other fire-rated structural elements, these plans and specifications shall be prepared by an architect registered in the State of South Carolina and shall bear his/her seal.

2. All plans shall be drawn to scale with the title and date shown thereon. Construction work shall not be started until approval of the final drawings or written permission has been received from the Department. Any construction changes from the approved documents require approval by the Department.

B. Preliminary submission shall include the following:

1. Plot plan showing size and shape of entire site; orientation and location of proposed building; location and description of any existing structures, adjacent streets, highways, sidewalks, railroads, et cetera, properly designated; size, characteristics and location of all existing public utilities, in-

cluding information concerning water supply available for fire protection;

2. Floor plans showing overall dimensions of buildings; locations, size and purpose of all rooms; location and size of doors, windows and other openings with swing of doors properly indicated; locations of smoke partitions and firewalls; locations of stairs, elevators, dumbwaiters, vertical shafts and chimneys;

3. Outline specifications listing a general description of construction including interior finishes and mechanical systems.

C. Final submission shall include the following: Complete working drawings and contract specifications, including layouts for plumbing, air conditioning, ventilation and electrical work and complete fire protection layout, if applicable.

D. In construction delayed for a period exceeding 12 months from the time of approval of final submission, a new evaluation and/or approval is required.

E. One complete set of as-built drawings shall be filed with DHEC.

SECTION 804. Licensure of Existing Structures (II)

When an existing structure is contemplated for licensure it must meet the same building code requirements as a "new" facility (see Section 803.A). If an expansion or renovation to an existing facility is contemplated, the facility must contact the Division of Health Facilities Construction of this Department to discuss code and regulatory requirements that

apply to that project. The following shall be submitted to the Department:

A. If the physical dimensions of the building are affected, a plot plan in accordance with Section 803.B.1;

B. A floor plan in accordance with Section 803.B.2;

C. Description of construction including outside walls, partitions, floor, ceiling and roof. The method of heating and cooling shall also be included.

NOTE: Those existing abortion clinics that have been identified by the Department, through submission of regular reports of abortions performed, may be licensed in their current buildings. However, upon initial licensure, these facilities will be required to submit a plan that will bring them into full compliance with this chapter within two years from date of licensure.

SECTION 805. Minor Alterations in Licensed Facilities

When alterations that involve construction that may affect walls, ceilings, floors, or fire and life safety are contemplated, preliminary drawings and specifications, accompanied by a narrative completely describing the proposed work, shall be submitted to the Department for review and approval to insure that the proposed alterations comply with current safety and building standards and determine if an architect need be involved.

SECTION 806. Location

A. Transportation. The facility must be served by roads that are passable at all times and are adequate for the volume of expected traffic.

B. Parking. The facility shall have parking space to reasonably satisfy the needs of patients, staff, and visitors.

C. Communications. A telephone must be provided on each floor used by patients and additional telephones or extensions must be provided, as required, to summon help in case of fire or other emergency. Pay station telephones are not acceptable for this purpose.

SECTION 807. Physical Facilities

A. An adequate number of examination/procedure rooms shall be provided. A procedure room shall be sized, shaped, and arranged to allow unfettered movement for all persons involved in the procedure.

B. Each procedure room shall be provided:

1. A suitable gynecological procedure table;

2. Equipment necessary to treat patients for hemorrhage, shock, cardiac arrest and other emergencies (an emergency "crash" cart in the immediate vicinity is acceptable); (I)

C. An area shall be provided for use by nurses in preparing medications for patients and keeping patient medical records. A room or cabinets shall be provided for storing medications and shall be kept locked

except when medications are being prepared for administering. Narcotics shall be double-locked. An adequate supply of drugs shall be on hand at all times.

D. An adequate number of recovery room(s) or area(s) shall be provided. There shall be clear space on both sides and at the foot of each recovery bed/recliner to allow unencumbered movement by staff and patients.

1. There shall be a toilet room immediately accessible from the recovery area. This room shall contain a commode with grab bars or recessed hand-holds and handwashing lavatory, operable without the use of hands, soap dispenser with soap, and paper towel dispensers with paper towels, or hot air dryer;

2. There shall be a signal system for each patient bath and toilet that shall include an audible alarm that can be heard and location identified by staff;

3. There shall be a readily accessible safe and sanitary storage area for patients' clothing and personal effects;

4. There must be provisions to afford privacy upon request of a patient, e.g., curtains, screens, private room.

E. A room for the temporary storage of soiled linen and waste in covered containers shall be provided. This room shall be provided with at least 10 air changes per hour with all air continuously exhausted to the outside.

F. There must be an area to accommodate the sterilization procedures as described in Section 602. There shall be sufficient surgical instruments sterilized and available for each patient who presents herself for abortion. The area shall be arranged to prevent cross traffic of clean and dirty material. Air flow in this area shall be from the "clean" area toward the "dirty" area.

G. Suitable dressing room space shall be provided for physicians and nursing staff. Scrub facilities shall be provided and located conveniently to the procedure room(s).

H. Procedure and recovery room(s) shall be located on an exit access corridor that provides unimpeded, rapid access to an exit of the building. This exit must accommodate emergency transportation vehicles and equipment.

I. In multi-storied buildings where the facility is not located on the floor of entry to/exit from the building, there must be at least one elevator that serves the clinic floor(s). The elevator must accommodate emergency transportation equipment.

J. Adequate fixed or portable work surface areas shall be maintained for use in each procedure room.

K. Doors providing access into the facility and procedure room(s) shall be at least 36 inches wide to accommodate maneuvering of ambulance stretchers and wheelchairs and other emergency equipment. All corridors shall be at least 48 inches wide.

L. Heating and ventilation.

1. Lighting, heating, and ventilation systems shall comply with local and state codes. There shall be approved equipment capable of maintaining a minimum temperature of 72 degrees Fahrenheit and a maximum temperature of 76 degrees Fahrenheit in patient areas.

2. The procedure room(s) and the recovery room(s) shall be provided a minimum of six air changes per hour. Air supplied to all areas shall be filtered through filters of at least 25 percent efficiency rating.

3. Mechanically operated systems shall be used to supply air to and exhaust air from soiled workrooms or soiled storage areas, janitor's closets, toilet rooms, and from spaces that are not provided with operable windows or outside doors.

M. The entrance shall be at grade level or above, be sheltered from the weather, and accommodate wheelchairs.

N. There shall be adequate storage areas for supplies and other storage. Sterile supplies shall be stored separate from other supplies.

O. One or more janitor's closets shall be provided throughout the facility as required to maintain a clean and sanitary environment. Each shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies.

P. A clean work area shall contain space for handwashing and clean storage and may include clean linen storage.

Q. There shall be at least two exits remote from each other.

R. Items such as drinking fountains, machines, and portable equipment or any other items shall not be located in the required exit corridors to restrict corridor traffic.

S. Thresholds and expansion joint covers shall be made sufficiently flush with the floor surface to accommodate wheeled service carts, wheelchairs, gurneys, etc.

T. All corridor glazing materials that extend within 18 inches of the floor shall be of safety glass, plastic, wireglass, or other material that will resist breaking and will not create dangerous cutting edges when broken. Safety glass or plastic glazing materials shall be used for any shower doors or bath enclosures.

U. Cubicle curtains and draperies shall be noncombustible or rendered flame retardant.

V. Wall finishes shall be washable and, in the immediate area of plumbing fixtures, shall be smooth and moisture resistant.

W. Wall bases in soiled equipment and material workrooms and other areas that are frequently subject to wet cleaning methods shall be tightly sealed and constructed without voids that can harbor insects.

X. Floor and wall penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

Y. Interior finish materials shall comply with the Standard Building Code requirements for "business occupancy."

Z. Adequate space shall be provided for reception, waiting, interviewing, administrative, and business office functions. Space provided for interviewing and admitting shall be located and designed to provide privacy.

SECTION 808. Water Supply and Plumbing (II)

A. Water Supply. Water shall be obtained from a community water system and shall be distributed to conveniently located taps and fixtures throughout the facility and shall be adequate in volume and pressure for all purposes including fire fighting. Patient and staff handwashing lavatories shall be supplied with hot water that shall be thermostatically controlled to a temperature between 100 and 125 degrees Fahrenheit.

B. Plumbing.

1. All plumbing material and plumbing systems or parts thereof installed shall meet the minimum requirements of the Standard Plumbing Code.

2. All plumbing shall be installed in such a manner as to prevent back siphonage or cross-connections between potable and non-potable water supplies. There shall be, at a minimum, an approved dou-

ble-check assembly on the water supply to the facility.

SECTION 809. Emergency Power and Lighting Requirements

A. The facility shall be equipped with automatic emergency power adequate to maintain the operation of lighting for procedure rooms, egress, fire detection equipment, and alarms. (I)

B. There shall be sufficient safe lighting for all activities, including suitable lighting for corridors. (II)

CHAPTER 9 - PREREQUISITES FOR INITIAL LICENSURE

Prior to admission of patients to, and issuance of a license for new facilities or additional procedure rooms, the following actions must be accomplished:

A. Plans and construction must be approved by the Division of Health Facilities Construction of this Department.

B. The facility shall submit a completed application for license on forms that shall be furnished by the Division of Health Licensing. The following documents shall be submitted with the application:

1. Final construction approval of both water and wastewater systems by the appropriate District Environmental Quality Control Office of this Department (includes satisfactory laboratory reports of water samples).

2. Approval from the appropriate building official stating that all applicable local codes and ordinances have been complied with.

   a. If the facility is located within town or ~~city~~ limits, approval by the local fire chief stating that all applicable requirements have been met, or

   b. If the facility is located outside town or city limits, a written letter of agreement with the nearest fire department that will provide protection and respond in case of fire at the facility shall be obtained. This letter shall indicate that they have the equipment, personnel, and/or agreements with other departments to adequately respond to this type of facility.

3. Certification and laboratory test reports, provided by the manufacturer or supplier, that all carpeting purchased by the facility meets the requirements of the Standard Building Code.

4. Certification by the contractor that only the carpeting described in B.3 above was installed in the facility.

5. Certification by the manufacturer or supplier that all drapes and cubicle curtains purchased by the facility are flame or fire resistant or retardant.

6. Certification by the owner or contractor that only materials described in B.5 above were installed.

7. Certification by the manufacturer or supplier that all wall covering materials purchased by the facility are fire or flame resistant or retardant.

8. Certification by the contractor that only the materials described in 7 above were installed.

9. Certification by the engineer that all fire alarm and smoke detection systems have been installed according to plans and specifications, have been tested and operate satisfactorily.

10. Certification by the contractor that the automatic sprinkler system, if required or installed, has been completed and tested in accordance with the approved plans and specifications and NFPA No. 13. Include a copy of the approval letter of the sprinkler shop drawings.

11. Certification that all medical gas systems have been properly installed and tested.

C. The facility must register as an infectious waste generator as outlined in Regulation 61-105.

D. Required personnel must be employed, available, trained, and capable of performing their duties.

E. The Division of Health Licensing shall inspect the facility and require compliance with these regulations.

F. The facility must pay the required licensing fee.

CHAPTER 10 - GENERAL

Conditions arising that have not been addressed in these regulations shall be managed in accordance with the best practices as interpreted by the Department.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM DEPOSITION OF
RICHARD GOODRICH
DECEMBER 15, 1997

[66]
9 I can't comment on this. I don't know how
10 you decide somebody is qualified.

***

[68]
12 A. I can see in writing regulations like this
13 It would be unduly restrictive because there are a
14 lot of physicians that are licensed and do not have
15 specialty training that could be capable of doing
16 the procedures, pelvic procedures. And I have known
17 through my experience — I don't know how
18 you go out and identify the people that are capable
19 of that, you know, if you don't have something to
20 look at.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPT FROM DEPOSITION OF
ROBERT A. LAWYER
FEBRUARY 3, 1998

[83]

A. Well, I think that would be courtesy. But a list would be fine. That's a referral.
Q. That would satisfy this requirement?
A. I believe it would.
Q. So they could basically have the yellow pages sections for these specialties?
A. That's carrying it a little far.
Q. It wouldn't satisfy you, if you were an inspector?
A. It would be a list, but I think I would look for something a little more concise.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPT FROM DEPOSITION OF
RICHARD O. MANNING
FEBRUARY 4, 1998

[45]

Q. Geographically, you indicated earlier, they come from all different parts of the state of South Carolina?
A. Yes.
Q. Is there one area they predominantly come from?
A. The area around Charleston, but we get them all the way from Georgia, North Carolina, and routinely see people from Columbia, quite often also from Greenville.
Q. Again, in some of those cities there are abortion facilities?
A. Yes.
Q. So they travel to your clinic because of its reputation?
A. Yes. Like in Greenville they always have picketers, so a lot of the people in Greenville don't want to walk through the picketers and get their picture taken so they will come to Charleston. Then I feel sure there are people from Charleston that drive to Greenville.
Q. For confidentiality purposes?
A. Confidentiality, yes.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM TRIAL TESTIMONY OF
WILLIAM LYNN
JULY 14, 1998

[165]

Q. Referring you down to 102.F.2 on that same page. Do you have concerns with regard to that section?
A. Yes, I do. It says, "Department inspectors shall have access to all properties, area, objects and records and reports." And this seems to be a violation of the patient's privacy and the referring physician's privacy, since it also requires that we record the referring physician later in the regulations, and could be detrimental to the doctor-patient relationship which is very important.
Q. And do you have any other concerns with reference to that section?
A. They're also allowed to make photocopies for the same ---
Q. You understand that to allow them to make photocopies of any of the records in the office?
A. Yes.

[166]

Q. That would include patients' records?
A. I assume that's what that means, yes.
Q. What are your concerns with reference to their being able to make photocopies of those documents?

A. I see no purpose of making photocopies if you're not going to remove them. And if they're taken and removed from my office, I lose control over any confidentiality I have with any of my patients.

***

[223]
understand. But section E requires that if the families of patients are involved in the care and services provided for the facility, there must be a means to obtain input from the families of the patients. And I really don't quite understand what that means. On the surface, I may. But our patients are frequently accompanied to the clinic by family and friends. Whether that constitutes involvement, the fact that they just come and accompany them and give them moral support or not, I'm not sure. I have had in the past some patients accompanied to my facilities by a family member who has absolutely no idea why she's there, and the patient does not want them to know. And this may require
[224]
breaking the confidentiality in letting them know why they're there when it's not desired by the patient.

***

[319]
them. But in Greenville, we have a tremendous problem with

harassment of patients and employees by antiabortion protestors. They've purchased the building next-door. They single out my employees as they come in. In the past, I've had these people write to my employees at home, call

[320]

them at home, protest in front of their homes. And many of my employees come and work for two or three days and leave, which I don't know is responsible – or I don't know is as a result of that, but I have very strong feelings that they don't want to put up with the harassment.

Q. And when you're referring to "they" picketing in front of employees homes, you're referring to the antiabortion persons doing so?

A. The same persons that protest in front of my office, antiabortion protestors.

Q. Is the level of protest activity associated with your Greenville facility higher than at your Beaufort facility?

A. Much higher.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM TRIAL TESTIMONY OF
THOMAS W. CAMPBELL
JULY 14, 1998

[371]

Q. Let me back up one more time to 102.F, which is on page six.
A. This having inspections just further decreases confidentiality of the patients. The Clinical Lab Enforcement Act comes in once every two years and they have access to any patient records. This would put some other person who may be antiabortion, pro-choice, whatever, you don't know what their status would be coming into your office looking over folks' records.

***

[420]

know, they'd be there at quarter till seven. I wouldn't want to – you'd have to get everybody there before you'd know there would be any patients because any kind – abortion clinics are – you know, there have been bomb threats, we have problems with protestors, we have all kinds of things. I wouldn't want to upset the patients as far as if I set off alarms and people go running out of the clinic and practicing this with all the patients there. I'd rather do it when they weren't.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM TRIAL TESTIMONY OF
LORRAINE D. MAGUIRE
JULY 15, 1998

[451]

Q. And have you, based on your experience working in abortion clinics, found that some patients – you mentioned that some patients from Beaufort come to your clinic. Have you found that sometimes patients seem to prefer not to go to a clinic in their own town?
A. Yes.
Q. Do you have an understanding as to why that is?
A. Confidentiality.

***

[457]

Q. Referring you now to 102.F, right below it. Do you have concerns with regard to the requirements set forth in 102 F?
A. I think that's vague to the point that I'm not sure when these inspections would take place, if it would take place during the normal day that we see patients and interfere with that.
Q. And referring you specifically also to 102.F Sub 2, do you have any concerns with respect to that provision?
A. It concerns me that DHEC could come in and, for

25 whatever reason, photocopy and remove documents from the
[458]
1 clinic. We have protestor problems in Charleston and they
2 have in the past gotten information from DHEC and brought
3 it back to the clinic and passed it out on the streets.
4 Q. And how do you know that protestors have obtained
5 documents from DHEC?
6 A. There is an induced termination of pregnancy report
7 that we're required to fill out on every abortion that we
8 do. One of my main protestors has gone to Columbia on
9 numerous occasions and made copies of several days' worth
10 of documents, brought them back, Xeroxed them on the back
11 of a letter that she passed out in my neighborhood.
12 Q. I'd like to hand you what's been marked as plaintiff's
13 exhibit eleven and plaintiff's exhibit twelve.
14 MR. ELLIOTT: Your Honor, we had interposed an
15 objection to plaintiff's exhibit twelve.
16 THE COURT: What is your objection?
17 MR. ELLIOTT: If your honor has a copy of it, it
18 might make more sense. Your honor, this is an exhibit that
19 is not a business record of the Charleston Women's Clinic.
20 As Ms. Maguire just testified, it was handed out in her
21 neighborhood. It's not signed by anybody, although it does
22 have the name of an organization on it. It's not addressed
23 to anybody. As a result, Your Honor, it's impossible to
24 authenticate, number one. And in addition, Your Honor,
25 it's not relevant because it does not go to any issue
[459]

involving Regulation 61-12.

THE COURT: It's relevant to the question of whether or not you have a legitimate concern about the ability of DHEC to keep this information confidential. Objection is overruled.

MS. ANDERSON: Thank you, Your Honor.

DIRECT EXAMINATION RESUMED BY MS. ANDERSON:

Q. Ms. Maguire, referring you to what I've just handed you as plaintiff's exhibit eleven and exhibit twelve, do you recognize these documents?

A. Yes.

Q. Have you seen these documents before?

A. Yes.

Q. When you first saw some other copy of these documents, were they two separate sheets or not?

A. No. They were one sheet Xeroxed front and back.

Q. So actually what is marked as twelve was on the back side of what's marked as eleven?

A. Yes.

Q. And how did you obtain a copy of this, what was then a two-sided, one-page document?

A. Off of my mailbox.

Q. And when you were just testifying regarding a protestor at your facility who had, to your knowledge, obtained documents that had been filed with DHEC, was this

[460]

document one that you were referring to?

A. Yes. And it's an accurate document, except for at the bottom where it says "problems after an abortion," that's a small business type card that they placed over a portion of

this paper and Xeroxed it. That's not part of the \
document.
Q. And when you're referring to the document, you're referring to what's specifically marked as exhibit eleven?
A. Eleven.
Q. So, in fact, with that exception you've just noted, exhibit eleven is indeed a copy of a document that your clinic had filed with DHEC?
A. Yes.

***

[500]
Q. Now, you have offered into evidence here a document that looks like an abortion procedure has been performed. Do you know where that came from? I don't remember the exhibit number off the top of my head, but I think it's either eleven or twelve.
A. Eleven.
Q. Yes, ma'am. That one you're holding. Do you know where it came from?
A. We fill out this form after the abortion is performed in our facility. And then it's sent to vital records at DHEC.
Q. That's the Bureau of Vital Statistics?
A. Yes.
Q. Do you know where that came from?
A. Yes. One of my protestors goes to Columbia, goes through the forms for any particular day, sometimes several days, she pays to get copies of these forms and then she brings them back. And sometimes she passes them out on the street, sometimes she just sends them into the building to
[501]

show me she knows how many abortions were performed.
In this particular case, she Xeroxed this on the back of a letter that she passed out to everybody in my neighborhood.
Q. Can I see that just a second? Do you know if this still is occurring?
A. What do you mean still current?
Q. Is this – do you still see these forms today, last week?
A. We still do those.
Q. Has there been any public dissemination of it, to your knowledge, after this incident?
A. Certainly. She periodically brings them.
Q. Now, this simply shows that an abortion was performed and has no names; is that correct?
MS. ANDERSON: Excuse me. Could I just ask that if he's going to ask the witness about the exhibit that he make sure she can see it.
MR. RICHARDSON: I'm going to hand it back to her. I was walking up there.
MS. ANDERSON: Thank you.
CROSS-EXAMINATION RESUMED BY MR. RICHARDSON:
Q. It has no names or identifying information other than a county; is that correct?
A. It has a number that we can identify, a patient chart number, and then the rest of it is just statistical

[502]

information. Recently, in Charleston, we had a patient that was sixteen years old that gave a zip code in the City of Charleston to a certain school district. And our protestor went there and protested at that high school

based on the zip code that she got off of one of these forms.
Q. And it's your testimony that you've seen those recently, in the last year?
A. Yes.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM TRIAL TESTIMONY OF
DAVID A. GRIMES
JULY 16, 1998

[729]

Q. And, Dr. Grimes, are you familiar with certain provisions of Regulation 61-12 that permit the Department of Health and Environmental Control to inspect abortion facilities and review and photocopy patient records in abortion facilities?

A. That was perhaps the most outrageous aspect of this document, from my perspective as a clinician with a quarter century experience.

Q. Why is that?

A. Absolutely outrageous violation of patient confidentiality. The notion that someone from Columbia can come in and start Xeroxing patient charts with identification, I wouldn't let them in the door.

***

[732]

Q. I'm sorry. I'm on page eleven, section 205.C.1. Can you tell me if you understand what qualifications, other than a license, a physician would need to have in order to be able to perform abortions in this state?

A. Well, I can't infer that by reading this sentence. It

says, "Who are properly qualified by training and experience." That's vague to me. So I can't answer.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM TRIAL TESTIMONY OF
GEORGE MOORE
JULY 16, 1998

[854]
25 Q. Could you look at Section 205.C.1 relating to the
[855]
1 qualifications of physicians. That section actually
2 requires the DHEC inspector to evaluate the training and
3 experience of a doctor to determine whether they're
4 qualified to perform abortions; is that correct?
5 A. Yes.
6 Q. And that assessment would be made on a
7 case-by-case basis by the inspector?
8 A. Yes.

***

[863]
3 Q. Well, what are the best practices as interpreted by
4 the department? What does that mean?
5 A. I think that that would have to be a case-by-case call
6 on the part of the inspector.
7 Q. Okay. Are you saying that anything that an inspector
8 found to be against the best practices as interpreted by
9 the department would have to be specifically included or
10 referenced in Regulation 61-12?
11 A. I don't – I'm not sure I understand your question
12 again. Please repeat it.
13 Q. Okay. I'm trying to figure out the best practices

that I guess can be violated under this particular section, whether those best practices are things that are described or identified in this regulation or whether they are things that exist outside the world of this regulation.
A. Well, I feel like that we would certainly classify – or let's just don't even say classify – interpret something that's seen that is not specifically referred to in the regulation as something that needs to be looked into. Usually what we do in cases like that when it's absolutely not covered anywhere else, we would go to the general paragraph which is at the end of the reg. I think that's essentially what we're talking about here, that that

[864]

would be a class three violation because part ten generally also talks about the best practices.
Q. Okay. So, in other words, a provider could commit a class three violation by doing something that is not, according to the words and terms of this regulation, prohibited?
A. If something is really seriously wrong in the eyes of the inspector that's not covered in a specific standard, we always have that option.
THE COURT: That question needs to be answered specifically yes or no. Repeat the question, please.
DIRECT EXAMINATION RESUMED BY MS. JONES:
Q. What I would like to know is whether the best practices, the violation of which can constitute a class three violation, whether those best practices are described and/or identified in this regulation?
A. No.

***

[873]

Q. I don't even know what it was anymore. I think my question was I believe that you stated previously that under this section, a physician would have to make prior arrangements with consultants ahead of time to insure that those consultants were immediately available should the physician wish to refer a patient to them; is that correct?
A. That's the intent of this section.
Q. That is your understanding?
A. That's my understanding.
Q. Could you – let me ask you one more thing. In the case of clergy, who would the doctor make that arrangement with?
A. Well, I would hope that the clinic would have some arrangements let's say for, as you spoke in the – or someone spoke in the deposition –
Q. It wasn't me.
A. It probably wouldn't be a Catholic priest, but maybe two or three different denominations just to be on call.
Q. How would they know which denominations?
A. Well, I think that we would just have to have Protestant and whatever else. I don't know. Again, I

***

[874]

Q. But the inspector will determine whether physicians have made sufficient consulting arrangements to satisfy the requirement of 307; isn't that right?
A. That's correct.

***

[875]
A. If we receive a complaint, we generally do an investigation to go find out if that's true or not. So it would be upon that visit for the investigation that we would make that determination as to whether or not the complaint was true or not.
Q. Let me ask you something else. Does DHEC take complaints over the telephone?
A. Yes.
Q. You take anonymous complaints?
A. Yes.
Q. So if someone calls and says this facility is not clean and they don't give you their name, you'd go check it out and do an investigation of that clinic?

[876]
A. Well, it depends on the severity of it. The complaint process undergoes a lot of evaluation all the time because we are essentially a complaint-driven health licensing section now. And some of the things that we do – we may very well wait if we don't feel like it's that important because of lack of resources. We will wait until the next regular visit rather than making a special visit.
Q. What if someone calls about something a little more significant? Let's say someone calls up and they say I don't really want to tell you who I am, but I think Dr. X has dirty instruments. Would you show up and do an inspection?
A. I think that would definitely call for an investigation
Q. And that investigation can be made unannounced?
A. Oh, yes.
Q. Probably would be in that circumstance, wouldn't it?
A. Oh, yes. The only announcements we do are initial licensing inspections.

Q. And you haven't given any thought to how many investigations you might be doing given the hotly contested issue involved in these regulations, have you?
A. It's come to my mind.
Q. Might be a lot, mightn't there?
A. Could be.

***

[914]
Q. What would be the reason that an inspector would need to photocopy records?
A. First of all, let me point out that it is hardly ever done. It's very rare. The only reason that we would have need to copy a record is if – usually it would be in conjunction with a complaint, and we either could not finish the examination of the record while we were at the site and needed to take a copy back to examine it more closely in the office or if there was possibly the need for it to be used in evidence, if there was a hearing, to go ahead and take that photocopy of that record to make sure that it was not altered from the time that we would have left the clinic until we got back to the office.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPT FROM TRIAL TESTIMONY OF
CHARLES J. WARD
JULY 17, 1998

[1063]
20 Q. Let's just do it again. Could you determine with any
21 certainty whether you were qualified?
22 A. Not with any certainty.

Plaintiffs' Exhibit 11

State of South Carolina
Department of Health and Environmental Control
Report of Induced Termination of Pregnancy

91 007706
State File Number

1. Facility Name (if not clinic or hospital, give address)
   CWMC

2. City, town, or location of pregnancy termination
   Chas

3. County of pregnancy termination
   Chas

4. Patient Identification Number
   (Do not enter patient's name)
   912665

5. Age last Birthday
   15

6. Married?
   [ ] Yes [✓] No

7. Date of Pregnancy Termination (Month, Day, Year)
   [*illegible*]

8a. Residence - State
   SC

8b. County
   Horry

8c. City, Town or Location
Murrells Inlet

8d. Inside City Limits
[✓] Yes [ ] No

8e. Zip Code
29576

9. Of Hispanic Origin?
(Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)
[ ] Yes [✓] No

10. Race
[ ] American Indian
[ ] Black
[✓] White
[ ] Other (*Specify*)_____

11. Education (Specify only highest grade completed)

Elementary/Secondary (0-12)	College (1-4 or 5+)
9	

12. Date last normal menses began (Month, Day, Year)
Jul. 6 91

13. Date of conception (Month, Day, Year)
Jul 23 91

14. Clinical Estimate of Gestation (Weeks)
7

15. Previous Pregnancies (Complete each section)

LIVE BIRTHS

15a. Now living
Number _____
[✓] None

15b. Now Dead
Number _____
[✓] None

OTHER TERMINATIONS

15c. Spontaneous
Number _____
[✓] None

15d. Induced (do not include this termination)
Number _____
[✓] None

16. TERMINATION PROCEDURES

16a. Procedure that terminated pregnancy
(check only one)

16b. Additional procedures used for this termination if any
(check all that apply)

TYPE OF TERMINATION PROCEDURES

1 [✓] ..... Suction Curettage ..... [ ] 1
2 [ ] ..... Sharp Curettage ..... [ ] 2
3 [ ] ..... Dilation and Evacuation (D&E) ..... [ ] 3
4 [ ] ..... Intra-Uterine Saline Instillation ..... [ ] 4
5 [ ] ..... Intra-Uterine Prostaglandin Instillation ..... [ ] 5
6 [ ] ..... Hysterotomy ..... [ ] 6
7 [ ] ..... Hysterectomy ..... [ ] 7
8 [ ] ..... Other (Specify_____) ..... [ ] 8
None ..... [✓] 0

17 - 18 CONSENT REQUIREMENTS
(Pursuant to Chapter 41, Title 44 of the Code of Laws of South Carolina, 1975, as amended)

17a. Was informed written consent obtained from the Patient?
[✓] Yes [ ] No

17b. If no, Informed Written Consent was not obtained due to:
(check one)
1 [ ] Medical Emergency
2 [ ] Incest
3 [ ] Not Capable/Mentally Incompetent
4 [ ] None of the Above

18a. If patient is under 17 years of age additional informed written consent obtained from:
(check one)
1 [ ] Parent
2 [ ] Legal Guardian
3 [ ] Grandparent
4 [✓] Person in Loco Parentis
5 [ ] None of the Above

Problems...
after an abortion?
MEDICAL • LEGAL • EMOTIONAL HELP
1-800-634-2224

19. Name of Attending Physician (type/print)
Richard O. Manning, M.D.

20. Name of Person Completing Report (type/print) ..... Title
C. Moore

21. Date Report completed (Month, Day, Year)
Aug. 27, 1991

For State office use only
22. Date report received
SEP. 09 1991

Plaintiffs' Exhibit 12

"S.C. Missionaries to the Unborn"

We have the sad responsibility to inform you that your neighbor Lorraine Maguire of 2215 Dawn Hill Dr. operates the state of South Carolina's largest abortion clinic. The Charleston Womens Medical Clinic at 1312 Ashley River Rd.

Lorraine personally supervised the violent brutal deaths of 3,000 helpless innocent unborn children in 1990 alone. This is according to DHEC statistics.

As women and mothers we can not understand how she can operate so grisly a business and prey on the most vunerable in our society, women in crisis and the most vunerable of all, little tiny babes that can't fight back?

You can understand Lorraines motivation however when you multiply those 3,000 deaths times $275.00, the average price to kill a child, you get a total of $875,000.000. Abortions are preformed at Lorraines clinic on tuesday, friday, and saturday for just a few hours in the morning or in the afternoon. Each porcedure only takes between 10 and 15 minutes. They line the women up and boom boom boom one ofter another. One doctor can preform as many as 30 abortions in one day.

The highest number of children killed at Lorraines clinic on one day, that we have been able to research, was August 17th 1990 when 34 children were killed. August 17th was a saturday, they close at 2pm on saturdays.

When you are faced with the grim statistics you have to face the reality that her main motivation for running a human slaughter house is GREED. Abortion is like drugs or pornography. People are going to get them, do them, and have them. Whether they are good for them or right for them or not. Woe to the ones through whom they come.

Lorriaine McGuire moved here from Greenville in 1985. She operated another clinic there. These clinics are part of a

ten clinic chain owned by two brothers Ernest and Mike Harris.

We would like to also share some information we obtained from a Tri-County Coalition for Choice meeting that four of our members infiltrated in October of 1991. Lorraine was listed on the program as one of the speakers. She never came however. The people running the meeting said she had a problem with a family member. A lawyer named Margaret Fabri spent 20 minutes explaining to the teenagers in the audiance. brought by the way as a youth group from a Luthern Church by their pastor Timothea Lewis who was also a member of the panel, how to get around the parental consent laws of our state. The last thing Ms. Fabri said was for the children not to try and remember all she said, just go to Lorraine she knows how to get around the law! We have included on the reverse of this flier a form that is filled out for abortions done in our state. The person who signed for this 15 year old girl to get an abortion was not one of her parents? The youngest child Lorraine helped preform an abortion on was 13 years old!

There are few businesses a women like Lorraine could go into that can generate nearly a million dollars a year from only 3 days a week work. Certainly not a cataring company or a florist. We feel so sorry for Lorraine Maguire and her family. The Bible clearly tells of God's judgement on people who shed innocent blood. If Cain was given a mark and lost fellowship with God for killing one innocent person, Able, what will become of Lorraine and those who participate with her in her evil trade? They have shed the blood of thousands of innocent children. Pray with us for her that she will repent!

S.C. Missionaries to the Unborn P.O. box 60593
N. Charleston, S.C. 29418
(803) 566-9675.

Plaintiffs' Exhibit 16 [Excerpt]

Guidelines for Women's Health Care was developed under the direction of the Committee on Professional Standards (1992-95):

Fredric D. Frigoletto, Jr, MD, Chairman
Leo J. Dunn, MD
Carla D. Harris, RN
Kenneth L. Noller, MD
Henry A. Thiede, MD
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Robert W. Yelverton, MD

Stanley Zinberg, MD, director of Practice Activities
Shirley A. Shelton, Associate Director, Clinical Practice

Rebecca D. Rinehart, Associate Director, Publications

Rick Johnston, Design

The information in *Guidelines for Women's Health Care* should not be viewed as a body of rigid rules. The guidelines are general and intended to be adapted to many different situations, taking into account the needs and resources particular to the locality, the institution, or the type of practice. Variations and innovations that improve the quality of patient care are to be encouraged rather than restricted. The purpose of these guidelines will be well served if they provide a firm basis on which local norms may be built.

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Defendants' Exhibit 18a [Excerpt]

ADMINISTRATIVE PROCEDURES

Personnel Policies and Procedures

NAF member facilities must provide vacation and sick-leave benefits for full-time staff members. NAF recommends an annual vacation leave of two weeks (ten days) and sick leave of one day per month (twelve days annually). Health insurance coverage is also recommended for employees of NAF member facilities.

A written job description including an outline of duties and qualifications should be available for each position. The job descriptions should be updated as duties change.

Performance appraisals should be in writing with the supervisors' and employees' signatures. Performance appraisals should be kept in the employee personnel folder along with other information pertaining to that employee. The employee has the right to review his/her personnel file upon request. The employee also has the right to an interview by his/her supervisor when requested.

The member facility should ensure there is appropriate professional liability (malpractice) coverage for the benefit and protection of the facility, its staff, and patients. Each facility should support Affirmative Action practices in staffing and advertising positions.

There must be a written and posted protocol for life-threatening medical emergencies. In addition there must be written descriptions of procedures and policies in each area of care, including:

-- nursing
-- counseling
-- abortion procedures
-- laboratory services

It is recommended that clinic hours be set considering the needs of the patients as well as the staff.

Clinic Security

Written guidelines must be available for all staff relating to nonmedical emergency procedures. These should be posted in a place appropriate for inspection by staff members.

It is recommended that a smoke and burglar alarm system be installed in each facility.

Patient Fees and Records

Each facility will have policies to accommodate low-income women. Specific financial arrangements should be made available to a minimum of ten percent of the patient load. There must be a contractual agreement between the woman and the facility outlining the payment plan and the collection policies. Collection policies must be in compliance with federal guidelines. The patient's record must not be released without the consent (preferably in writing) of the patient.

Confidentiality

Every woman has the right to expect her privacy will be respected and confidentiality of her records protected. Since most states do not have legislation protecting the confidentiality of medical records, care should be taken when making a notation on her record (particularly counseling notes). In addition, if a member of the facility receives a subpoena for a woman's records, action must be taken to prohibit the release of the records without the woman's consent.

Additional suggestions to protect confidentiality are:

-- keep all doors locked in accordance with fire code except the door where the patients enter;

-- before discarding, shred all waste paper that may have a patient's name or information;

-- each night, lock all information with patients' names, including appointment books and daily logs;
-- keep any and all paperwork with identifying names and numbers in desks – not unattended in full view of others in the clinic; and,
-- never disclose to a telephone caller information about a patient that may be in the facility, rather state that if that person is in the facility you will deliver a message to have the patient return the call.

Minors

Minors should be served in the same manner as other women, keeping in mind possible restrictions upon hospital admission without parental consent. If hospitals will not admit without parental consent, minors should be made aware that, in case of emergency, it may not be possible to maintain confidentiality.

Administrative Supervision

While direct professional supervision of physicians, nurses, and counselors is the responsibility of the senior professional in each area, the chief administrative officer responsible for the general supervision of clinic functions should assure that personnel policies and procedures are formulated, distributed, and observed in an equitable manner.

In a professional organization such as an abortion service, this includes the arrangements for continuing training in the form of individual supervision, in-service education programs, and continuing education opportunities for all professional and paraprofessional staff members.

Individual agencies are responsible for knowledge of current local nurse practice acts. Agencies may not require nurses to practice outside the legal limits of local nurse practice acts.

Agencies are also responsible for knowledge of the current state of licensure and professional liability insurance for physicians engaged in medical practice within the facility or those acting in its name.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

DECLARATION OF TERRY BUFFKIN, M.D.
[Excerpt]

21. Third, I am extremely concerned about the fact that the Regulation permits DHEC employees to access, copy and remove our patients' records without prior notice, yet does not require DHEC to maintain those records (and the information contained in them) in strict confidence. This provision is inconsistent with safeguarding our patients' privacy, health and welfare. Indeed, it absolutely prevents me from ensuring the privacy of my patients' identities and medical conditions. Once DHEC removes a patient record from our office, I would have no control over who has access to that record. This would constitute a substantial breach of our patients' confidentiality, and it may dissuade some of them from seeking care at our facility or any other licensed facility in the State.

22. The Regulation also threatens our patients' confidentiality and well-being by requiring them to provide their husbands' names for our medical records. It is my opinion that, for a variety of reasons, many patients will not want to give us this information, and may therefore provide us false information about their identities.

23. Discouraging women from seeking health care from their physicians and encouraging them to provide false information to their physicians threaten women's health.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

DECLARATION OF WILLIAM LYNN, M.D.
[Excerpt]

1 I also provided abortion services for many years in my office in Beaufort. Subsequent to the trial in this case, my landlord decided not to renew my lease. At that time, I decided that it would not be economically feasible for me to reopen my Beaufort practice in another location. This decision was based on a number of factors, including the costs of moving the practice, and the costs of complying with the Regulation.

***

21. Second, the Regulation permits the Department of Health and Environmental Control ("DHEC") to inspect, copy and remove patients' records from my office. This causes a substantial breach of the confidential relationship that I maintain with my patients. In my opinion, many of my patients will be reluctant to get abortions if their confidentiality cannot be maintained. My patients are already very concerned about confidentiality and they often ask me numerous questions about whether their identity will be disclosed to anyone outside of our office. I am concerned that if the Regulation takes effect, some of my patients will attempt to self-abort or to obtain abortions from unlicensed persons, or will be forced to travel to other states in an attempt to maintain their confidentiality.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

DECLARATION OF GARY BOYLE, M.D.
[Excerpt]

23. Third, I am extremely disturbed by the provision in the regulation that permits DHEC to inspect, remove and copy patient records. Confidentiality is critical to abortion patients, and we work very hard to maintain that confidentiality. If this provision goes into effect, I believe that we will have to inform our patients that their records may be obtained by DHEC. This will surely frighten and anger many of our patients. It may also force patients to delay their abortions until they can go to another state where their confidentiality will be maintained or to attempt to self-abort. Either alternative poses very serious risks to the patients' health and well-being.